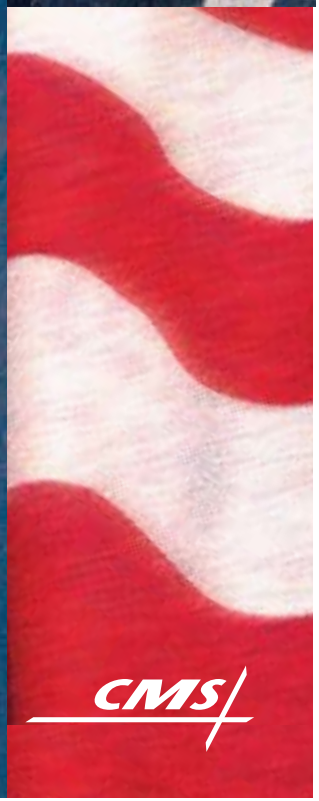
U.S. Department of Health & Human Services
Centers for Medicare & Medicaid Services

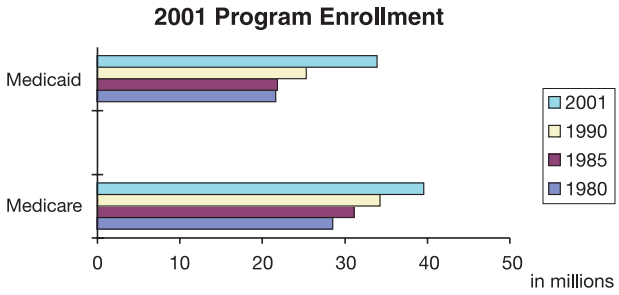
# CMS Financial Report

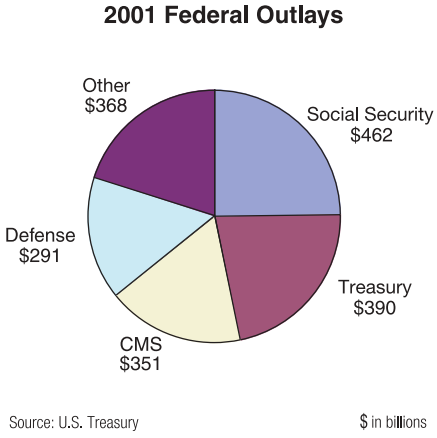
*Fiscal Year 2001*



# The Centers for Medicare & Medicaid Services At a Glance

**CMS** is the largest purchaser of health care in the world. The Medicare, Medicaid, and State Children's Health Insurance programs that we administer provide health care for one in four Americans. Medicare enrollment has increased from 19 million beneficiaries in 1966 to 40 million beneficiaries. Medicaid enrollment has increased from 10 million beneficiaries in 1967 to 34 million beneficiaries.




**CMS** outlayed $351.1 billion (net of offsetting receipts) in fiscal year (FY) 2001, 18.9 percent of total Federal outlays. The only agencies that outlayed more are the Social Security Administration and the Department of the Treasury.

**CMS** has approximately 4,600 Federal employees, but does most of its work through third parties. CMS and its contractors process 930 million Medicare claims annually, monitor quality of care, provide States with matching funds for Medicaid benefits, and develop policies and procedures designed to give the best possible service to beneficiaries. We also assure the safety and quality of medical facilities, provide health insurance protections to workers changing jobs, and maintain the largest collection of health care data in the United States.

## CMS and Its Partners

| | Employees |
|---|---|
| CMS | 4,600 |
| State Medicaid/SCHIP | 34,000 |
| Medicare Contractors | 22,400 |
| State Surveyors | 6,200 |
| Peer Review | 2,600 |

***Administrator***
Washington, DC 20201

## *A Message from the Administrator*

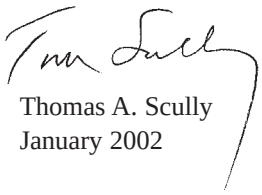
I am pleased to provide the Centers for Medicare & Medicaid Services (CMS) Financial Report for fiscal year (FY) 2001. As the Nation's largest health insurer, CMS provides coverage to about 70 million beneficiaries. Our programs—Medicare, Medicaid, and the State Children's Health Insurance Program—accounted for about $350 billion in FY 2001 outlays and represented the Federal Government's third largest outlay.

The CMS has been increasingly aware that moving forward to change the Agency and to develop a more friendly association with its community of beneficiaries and partners is critical to the fulfillment of our Agency's vision—to lead the Nation's health care system in providing improved health care for all. In this transition year, CMS changed its name and restructured around three business centers (Center for Medicare Management, Center for Beneficiary Choices, and Center for Medicaid and State Operations), each one focusing on its core expertise.

With our new name and new identity, there are several new initiatives that will reform and strengthen CMS. President Bush announced the prescription drug discount card, which will provide immediate relief to millions of seniors through the teamwork that crosses several CMS components. Our work to bring a prescription drug benefit is not complete, but this is a good first step. We have created a culture of responsiveness within—and outside—CMS. We are more responsive to the concerns of those who treat our beneficiaries: the doctors, hospitals, health plans, laboratories, suppliers, and other health care providers. We have created monthly Open Door Policy Forums for seven provider and beneficiary groups. We are holding a series of listening sessions across the country in order to hear directly from physicians and health care providers. And we are creating in-house expert teams throughout CMS so as to share innovative ways to do business.

Last fall, we launched a national advertising campaign to include television, radio, and print ads as part of our Medicare education initiative that will make it easier for Medicare beneficiaries to learn about their choices and become informed participants. We have expanded our Call Center services at 1-800-MEDICARE (1-800-633-4227) to provide direct customer service responding to questions from seniors and their caregivers 24 hours a day, 7 days a week. In addition, we have enhanced our Medicare consumer information Web site, *www.medicare.gov*, to allow users to find health plan choices by their zip code. This will help our beneficiaries better understand all the health care options available to them. We plan to reform the contracting process and will work closely with health care providers in developing Medicare contracting reform legislation, which will allow CMS to operate more efficiently and effectively.

All of our work has but one focus: the best health care possible for our Nation's beneficiaries.



Thomas A. Scully
January 2002

***Deputy Administrator and Chief Operating Officer***

Baltimore, MD 21244-1850

## *A Message from the Deputy Administrator and Chief Operating Officer*

As the Deputy Administrator and Chief Operating Officer of the Centers for Medicare & Medicaid Services (CMS), I am pleased to join the Administrator and the Chief Financial Officer in presenting CMS's Financial Report for fiscal year (FY) 2001. This report provides a comprehensive picture of CMS's FY 2001 performance and discusses many important programmatic, financial, and management initiatives.

President George W. Bush and the Department of Health and Human Services (HHS) Secretary Tommy Thompson have made improving the delivery of public services a cornerstone of our Administration. In response to this calling, CMS has taken the necessary steps to deploy resources in a more customer-oriented way. We reviewed the Agency's functions and reorganized some CMS responsibilities and operations in order to be more responsive to our customers and partners. We developed a restructuring and management plan, with a strong focus toward delayering, as a strategic step in moving the Agency to be more citizen-centered, results-oriented, and market-aware. We began our "open door" program to provide opportunities for interests across the health care spectrum to regularly discuss issues directly with senior CMS officials. Among our foremost priorities is the development of a new financial management infrastructure to support the Healthcare Integrated General Ledger Accounting System. Commonly called "The HIGLAS project," this effort is a critical HHS and CMS initiative that will significantly enhance Medicare accounting processes.

At CMS, we recognize that a key component of customer service is operational improvement. An organization that is efficiently staffed and well managed is much more responsive and generates far fewer causes of customer complaints. In light of this, we established a Project Management team and an Internal Audit unit to strengthen our day-to-day operations. These new units will work with all of the CMS components, the Risk Management unit, and the Regional Offices to improve our internal processes. These additions will result in our enhanced ability to implement program updates, Congressional mandates, and new initiatives.

Timeliness, reliability, and accountability are all hallmarks of all effective organizations. As you will see in this report, we have begun to make significant improvements in these areas and are planning many more. I trust that you will find this report helpful and informative. We look forward to continue serving the seventy million Americans who depend on our programs with integrity, quality, and ever-improving customer service.

Ruben J. King-Shaw, Jr.
January 2002

## A Message from the Chief Financial Officer

As the Chief Financial Officer (CFO), I am pleased to present CMS's Financial Report for FY 2001. As an Agency with outlays totaling about $350 billion, CMS manages the Medicare, Medicaid, and the State Children's Health Insurance Programs. The CMS continues to play a proactive role in our partnerships with the Department of Health and Human Services (HHS), the Office of Inspector General, State agencies, Medicare contractors, and our beneficiaries.

An important indicator of our ability to effectively manage our programs is our ability to produce timely and accurate financial statements that can be used for decision-making. I would like to commend the Medicare contractors for their dedication to improved financial management, especially in the processing and reporting of accounts receivable. Therefore, I am pleased to report that for FY 2001, CMS's financial statements have once again received an unqualified audit opinion. This marks the third consecutive year that CMS has received such an opinion.

This report presents the financial health of Medicare's Hospital Insurance and Supplementary Medical Insurance Trust Funds separately, based on standards in effect at the time of the audit. Going forward, the Administration plans to develop a more comprehensive measure of Medicare's financial position that will analyze the Medicare program as a whole.

A key element of our strategic vision is to implement a state-of-the-art financial management system that fully integrates CMS's accounting systems with those of our Medicare contractors. This project is the Healthcare Integrated General Ledger Accounting System (HIGLAS). HIGLAS will also strengthen Medicare's management of its accounts receivable and allow more effective collection activities on outstanding debt. This project is well underway. On September 26, 2001, CMS awarded the HIGLAS contract to PricewaterhouseCoopers (PwC), whose major teaming partners include Oracle Corporation and Electronic Data Systems (EDS). The implementation plan includes pilots at two Medicare contractors that will start operational implementation in October 2002. If these two pilots are successful, HIGLAS will be implemented at all Medicare contractor sites. Our goal is to have HIGLAS fully implemented at all Medicare contractors by 2006.

Last year we developed a Chief Financial Officer Comprehensive Plan for Financial Management to provide a coordinated approach to address our financial management goals. The plan highlights 10 goals that are supported by 25 initiatives critical to CMS's ability for sustaining a clean audit opinion and improving financial management. While we are still implementing some of the initiatives, we are proud of the many projects and activities CMS successfully achieved this year that have greatly improved financial reporting and Medicare contractor oversight. During FY 2001, CMS:

- revised and issued contractor financial reporting instructions to enable contractors, CMS central and regional offices to provide accurate and complete financial data and improve the consistency of financial information reported.
- hosted two national CFO training conferences to ensure that the new policies and procedures are understood and improve the accuracy and reliability of reported financial information.
- held a conference for the Medicare contractors' Chief Financial Officer for Medicare Operations to stress CMS's expectations and commitment to improving financial management and emphasize the importance of debt referral and internal controls.
- developed a searchable database of contractor financial management guidance and instructions that is available on the internet.
- updated the Medicare contractor internal control objectives and issued guidance for evaluating internal controls including methodologies for assessing risk.

- published an accounting procedures manual, which will ensure that accounting transactions are treated consistently, accounting principles are proper, and our financial statements comply with applicable laws and regulatory requirements.
- developed a process for following up on Medicare contractors' corrective action plans to ensure the timely resolution of weaknesses identified during financial management audits and other reviews.
- developed analytical tools necessary to perform more expansive trend analysis of critical financial related data, specifically account receivables and interim financial statements.

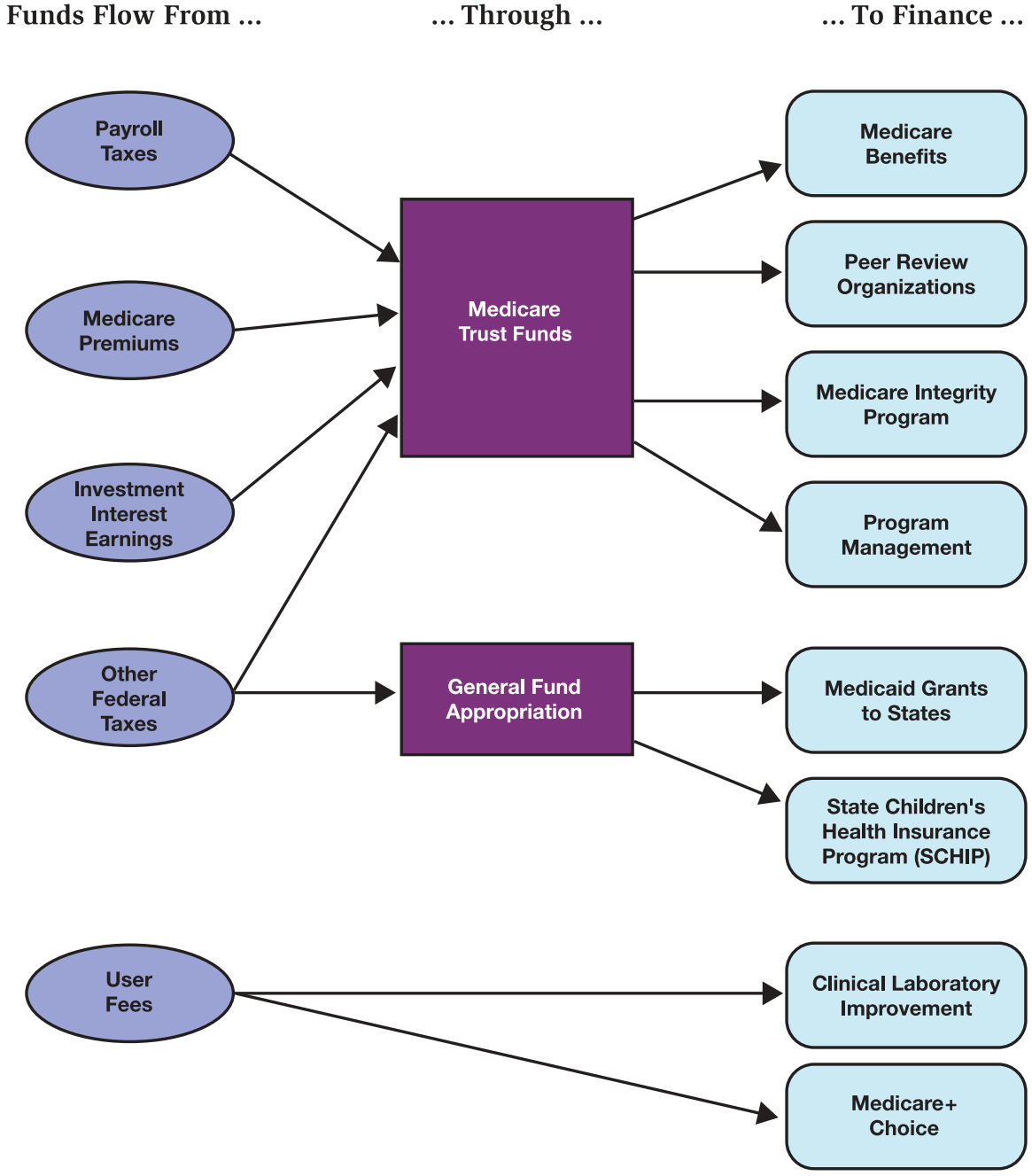
I am also pleased to report that we continue to a make substantive progress in the successful implementation of the Debt Collection Improvement Act. In FY 2001, we focused on expanding the debt referral process to all Medicare contractors and CMS regional offices and referred an additional $2.1 billion of delinquent debt for collection to the Department of Treasury. This brought the Agency's total delinquent debt referred for collection to about $4 billion. Our ultimate goal is to have 100 percent of eligible delinquent debt referred by the end of FY 2002. In addition, CMS will contract for services that will identify unreported debt from entities associated with our Medicare contractors.

We have also implemented aggressive efforts to reduce fraud, waste, and abuse in the Medicare and Medicaid programs. For example, we have made significant progress to reduce the Medicare payment error rate since 1996. The Office of Inspector General reported that the Medicare fee-for-service error rate is 6.3 percent in FY 2001. We will continue our program integrity strategies to achieve our 2002 Government Performance and Results Act goal of achieving a 5 percent CFO audit Medicare fee-for-service error rate and increase efficiency, effectiveness, and consistency in the application of Medicare coverage and payment rules. Furthermore, we addressed the majority of OIG's list of CMS's Management and Performance Challenges.

While many improvements were achieved over the past year, we must continue our financial management commitment. Building on the successful implementation of our CFO Comprehensive Plan for Financial Management, I believe that we have a clear vision and focus as we strive to improve our financial operations. As the CFO, I remain fully committed to the stewardship responsibilities needed to continue to maintain the highest level of accountability for the management of the Agency's financial resources.

A. Michelle Snyder
January 2002

# Financing of CMS Programs and Operations



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As of February, 2002

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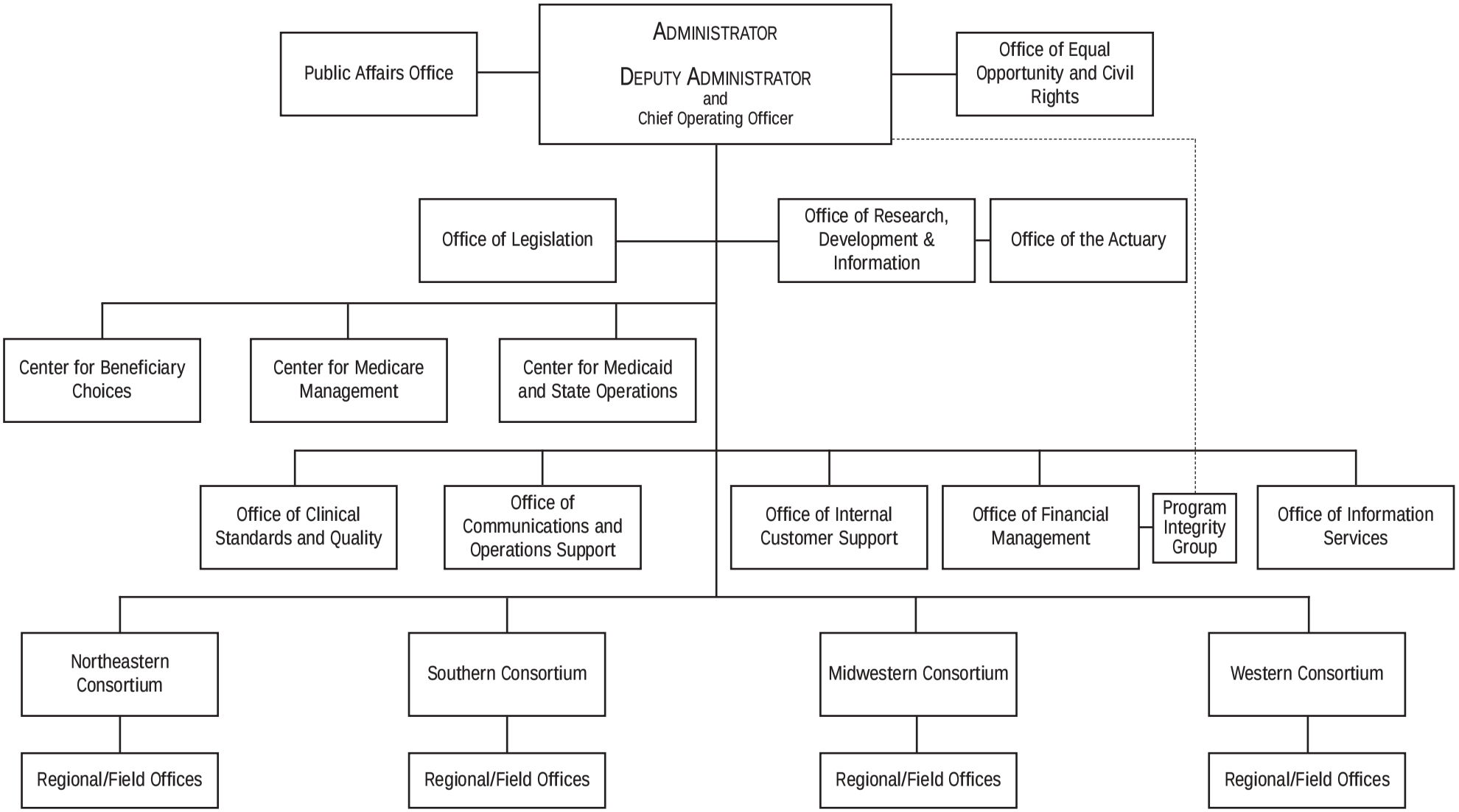


U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services


# Management's Discussion and Analysis

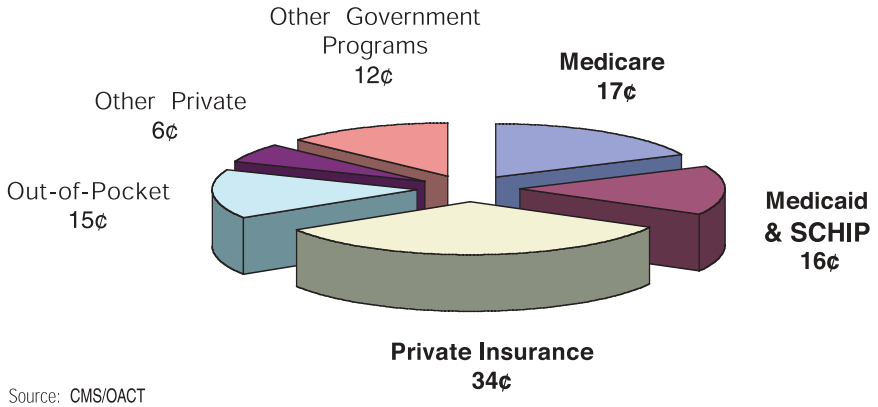
CMS

# OVERVIEW

The Centers for Medicare & Medicaid Services (CMS), an operating division of the Department of Health and Human Services (HHS), administers Medicare, Medicaid, State Children's Health Insurance Program (SCHIP), and the Clinical Laboratory Improvement program. Along with the Departments of Labor and Treasury, CMS also implements the insurance reform provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

CMS is the largest purchaser of health care in the world. Medicare, Medicaid, and SCHIP outlays, including State funding, represent 33 cents of every dollar spent on health care in the United States (U.S.)—58 cents of every dollar spent on nursing homes, 48 cents of every dollar received by U.S. hospitals, and 28 cents of every dollar spent on physician services.

**The Nation's Health Care Dollar 2000**




Source: CMS/OACT
Note: 2000 is most current data available

CMS outlays totaled $351.1 billion (net of offsetting receipts) in fiscal year 2001. CMS establishes rules for program eligibility and benefit coverage; processes 930 million claims annually; provides States with funds for the Medicaid and the State Children's Health Insurance Programs; ensures quality of health care for beneficiaries; safeguards funds from fraud, waste, and abuse; and carries out other important activities.

Of CMS's 4,600 Federal employees, about 1,600 work in 10 regional offices around the country providing direct services to Medicare contractors, State agencies, health care providers, beneficiaries, and the general public. Approximately 3,000 of CMS's employees work in Baltimore, MD and Washington, D.C., where they provide funds to Medicare

contractors; write policies and regulations; set payment rates; safeguard the fiscal integrity of the Medicare and Medicaid programs to ensure that benefit payments for medically necessary services are paid correctly the first time; recover improper payments; assist law enforcement agencies in the prosecution of fraudulent activities; monitor contractor performance; develop and implement customer service improvements; provide education and outreach activities to beneficiaries, survey hospitals, nursing homes, labs, home health agencies and other health care facilities; work with State insurance companies; and assist States and Territories with Medicaid and the State Children's Health Insurance Programs. In addition, CMS maintains the Nation's largest collection of health care data and provides data and technical assistance to the Congress, the Executive Branch, universities, and other private sector researchers.

**Two key financial terms** are critical to understanding the CMS financial story. **Expenses** are one of the ingredients of the financial statements that begin on page 51. Expenses are computed using accrual accounting techniques which recognize costs when incurred and revenues when earned and include the effect of accounts receivable and accounts payable on determining net cost of operations. Wherever possible, expenses are the basis for discussions of CMS's financial activity. **Outlays** refer to the issuance of checks, disbursement of cash, or electronic transfer of funds made to liquidate an expense regardless of the fiscal year the service was provided or the expense was incurred. Outlays are used in the discussions of CMS's financial activity only when comparable expense data are not available.

In FY 2001, CMS's expenses totaled $376.2 billion. CMS's administrative expenses totaled $2.4 billion, which is less than one percent of total expenses. In addition to CMS's 4,600 employees, many important operational activities are handled by third parties: (1) 34,000 State employees have responsibility for administering the Medicaid and State Children's Health Insurance Programs; (2) 22,400 employees at 50 Medicare contractors have primary responsibility for processing Medicare claims, providing technical assistance to providers and servicing beneficiaries needs, including premium billing, and responding to inquiries; (3) 6,200 State employees have primary responsibility for inspecting hospitals, nursing homes, and other facilities to ensure that health and safety standards are met; and (4) 2,600 employees at 53 Peer Review Organizations (PROs) conduct a wide variety of quality improvement programs to ensure quality of care provided to Medicare beneficiaries.

The strength of CMS was confirmed in the aftermath of the September 11 terrorist attacks when the Agency quickly prepared for increased demand for emergency and other health care services. We also issued monetary advances to ten New York area hospitals that experienced problems with cash flow and meeting payrolls. Our rapid response assured that all Medicare, Medicaid, and SCHIP beneficiaries had access to proper medical services and that providers received compensation for covered services.

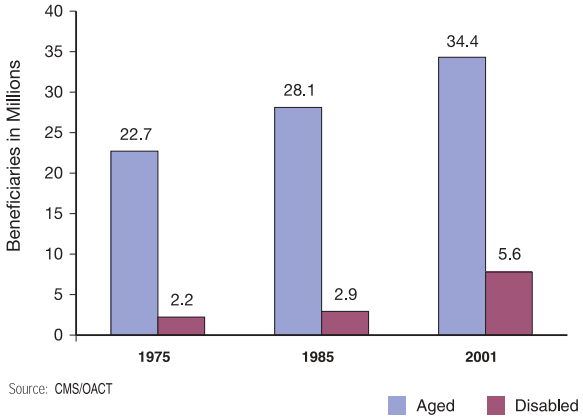
# PROGRAMS

## Medicare

### Introduction

Established in 1965 as Title XVIII of the Social Security Act, Medicare was legislated as a complement to Social Security retirement, survivors, and disability benefits, and originally covered people age 65 and over. In 1972, the program was changed to cover the disabled, people with end-stage renal disease (ESRD) requiring dialysis or kidney transplant, and people age 65 or older who elect to purchase Medicare coverage.

**Medicare Enrollment**



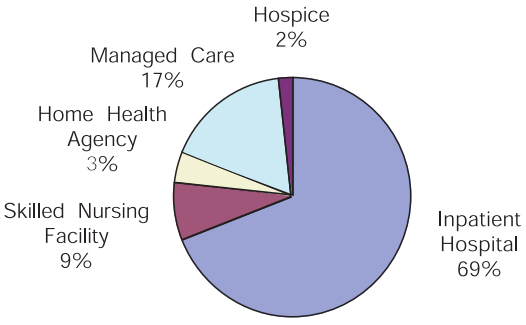

Source: CMS/OACT

Medicare processes 930 million fee-for-service claims a year, is the nation's largest purchaser of managed care, and accounts for 18.9 percent of the Federal Budget. Medicare is a combination of three programs: Hospital Insurance, Supplementary Medical Insurance, and Medicare +Choice. Since 1966, Medicare enrollment has increased from 19 million to 40 million beneficiaries.

### Hospital Insurance

Hospital Insurance, also known as HI or Medicare Part A, is usually provided automatically to people age 65 and over who have worked long enough to qualify for Social Security benefits and to most disabled people entitled to Social Security or Railroad Retirement benefits. HI pays for hospital, skilled nursing facility, home health, and hospice care.

**HI Medicare Benefit Payments**




Source: CMS/OACT

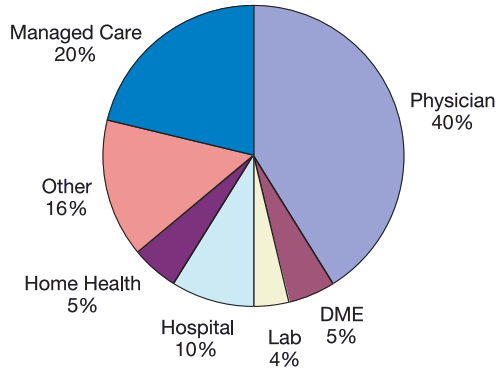
The HI program is financed primarily by payroll taxes paid by workers and employers. The taxes paid each year are used mainly to pay benefits for current beneficiaries. Funds not currently needed to pay benefits and related expenses are held in the HI trust fund, and invested in U.S. Treasury securities.

Inpatient hospital spending accounted for 69 percent of HI benefits outlays. Managed care spending comprised 17

percent of total HI spending. During FY 2001, HI benefit outlays grew by 9.2 percent. HI benefit outlays per enrollee increased 8.0 percent to $3,530.

## Supplementary Medical Insurance

**SMI Medicare Benefit Payments**




Source: CMS/OACT

Supplementary Medical Insurance, also known as SMI or Medicare Part B, is available to nearly all people age 65 and over, the disabled, and people with ESRD who are entitled to Part A benefits. The SMI program pays for physician, outpatient hospital, home health, laboratory tests, durable medical equipment, designated therapy, and other services not covered by HI. The SMI coverage is optional and beneficiaries are subject to monthly premium payments. About 95 percent of HI enrollees elect to enroll in SMI.

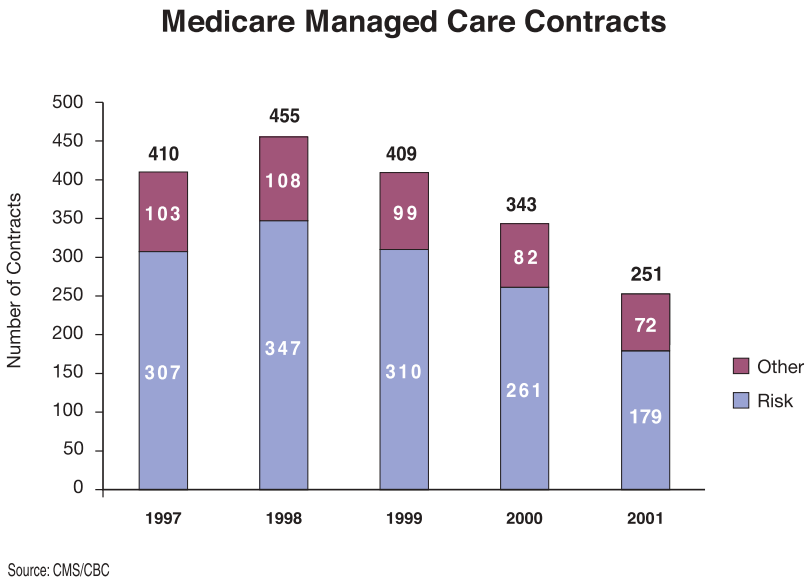
The SMI program is financed primarily by transfers from the general fund of the U.S. Treasury and by monthly premiums paid by beneficiaries. Funds not currently needed to pay benefits and related expenses are held in the SMI Trust Fund, and invested in U.S. Treasury securities.

During FY 2001, SMI benefit outlays grew by 11.7 percent. Physician services, the largest component of SMI, accounted for 40 percent of SMI benefit outlays. SMI benefit outlays per enrollee increased 10.7 percent to $2,580.

## Medicare+Choice

The Balanced Budget Act of 1997 (BBA) created Medicare+Choice (M+C), sometimes referred to as Medicare Part C. With the exception of those with end stage renal disease, any Medicare beneficiary entitled to both Part A and B benefits may join a M+C plan if one is available in his or her area.

The BBA's goal is to make Medicare attractive for private plans by providing health insurance choices to beneficiaries. In creating the M+C program, the BBA restructured the capitation rates for Medicare managed care and provided user fees to fund a consumer information campaign, which provided beneficiaries with comparative plan information. Although there have been concerns over plans leaving the Medicare program, the number of managed care plans increased from 193 in FY 1993 to 251 contracts (coordinated care plans, cost-based contracts, demonstrations, and Health Care Prepayment Plans (HCPP)) in FY 2001. Medicare beneficiaries have long had the option to choose to enroll in prepaid health care plans that participate in Medicare instead of receiving services under traditional fee-for-service (FFS) arrangements.



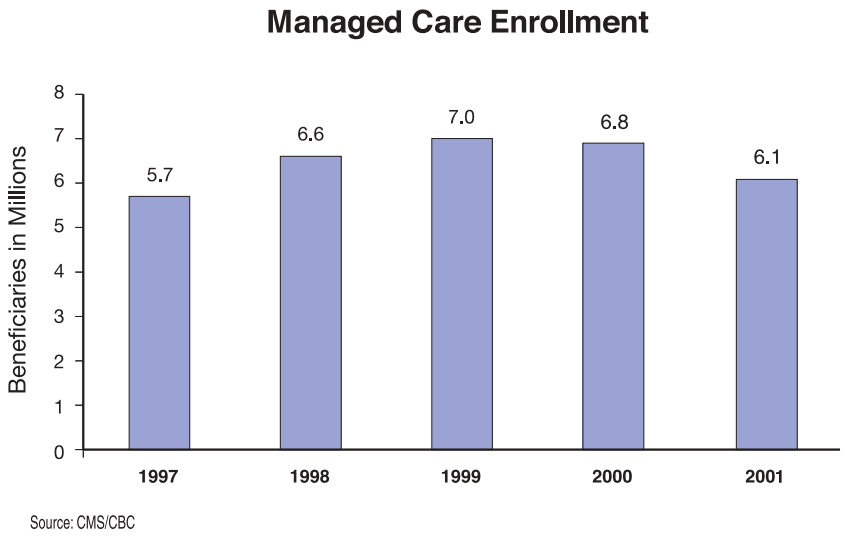

Source: CMS/CBC

Managed care organizations have their own providers or a network of contracting health care providers who agree to provide health care services for health maintenance organizations (HMO) or prepaid health organization's members. Managed care organizations currently serve Medicare beneficiaries through coordinated care plans, which include HMOs, point-of-service (POS) plans offered by HMOs, preferred provider organizations (PPOs), and provider-sponsored organizations (PSOs). Under M+C, beneficiaries may also choose to join a private FFS plan that is available in twenty-five States. Managed care demonstration projects, as well as cost and HCPP options, also exist.

All M+C plans are paid a per capita premium, assume full financial risk for all care provided to Medicare beneficiaries, and must provide all Medicare covered services. Many M+C plans offer additional services such as prescription drugs, vision and dental benefits to beneficiaries. Cost contractors are paid a pre-determined monthly amount per beneficiary based on a total estimated budget. Adjustments to that payment are made at the end of the year for any variations from the budget. Cost plans must provide all Medicare-covered services, but do not always provide the additional services that some risk M+C plans offer. HCPPs are paid in a manner similar to cost contractors, but cover only Part B Medicare services. Section 1876 cost-based contractors and HCPPs, with certain limited exceptions, phase out under the BBA provisions.

Since 1997, Medicare beneficiaries enrollment in managed care plans has increased from 5.7 million to 6.1 million in 2001, which represents 15 percent of the total Medicare population. Managed care expenses accounted for $42.0 billion of the total $239.8 billion in Medicare benefit payment expenses in FY 2001.

In FY 2002, about 90 percent of current M+C beneficiaries will be able to continue with their current Medicare HMO. Twenty-two M+C HMOs chose not to renew their M+C contracts and 36 reduced their service areas, affecting more than 536,000 Medicare beneficiaries. About 446,000 of the affected beneficiaries will be able to enroll in




another M+C Coordinated Care Plan (CCP) if the plan is accepting enrollees. About 90,000 beneficiaries will be left with no M+C CCP options, although some may choose to enroll in a private FFS plan if one is available in their community. All beneficiaries who are affected by these nonrenewals may return to original FFS Medicare.

# Medicaid

## *Introduction*

Medicaid is the means-tested health care program for low-income Americans, administered by CMS in partnership with the States. Enacted in 1965 as title XIX of the Social Security Act, Medicaid was originally legislated to provide medical assistance to recipients of cash assistance. Over the years, Congress incrementally expanded Medicaid well beyond the traditional population of the low-income elderly and the blind and disabled. Today, Medicaid is the primary source of health care for a much larger population of medically vulnerable Americans, including poor families, the disabled, and persons with developmental disabilities requiring long-term care. The average enrollment for Medicaid was 34 million in 2001, about 12 percent of the U.S. population. Approximately 6 million people are dually eligible, that is, covered by both Medicare and Medicaid.

CMS provides matching payments to States and Territories to cover the Medicaid program and related administrative costs. State medical assistance payments are matched according to a formula relating each State's per capita income to the national average. In FY 2001, the Federal matching rate for Medicaid program costs among the States ranged from 50 to 77 percent, with a national average of 56 percent. Federal matching rates for various State and local administrative costs are set by statute, and in FY 2001 averaged 56 percent. Medicaid payments are funded by Federal general revenues provided to CMS through the annual Labor/HHS/Education appropriations act.

There is no cap on Federal matching payments to States, except with respect to the disproportionate share program and payments to Territories.

States set eligibility, coverage, and payment standards within broad statutory and regulatory guidelines that include providing coverage to persons receiving Supplemental Security Income (disabled, blind, and elderly population), low income families, the medically needy, pregnant women, young children, low-income Medicare beneficiaries, and certain other groups; and covering at least 10 services mandated by law, including hospital and physician services, laboratory tests, family planning services, nursing facility services, and comprehensive health services for individuals under age 21. State governments have a great deal of programmatic flexibility to tailor their Medicaid programs to individual State circumstances and priorities. Accordingly, there is a wide variation in the services offered by States.

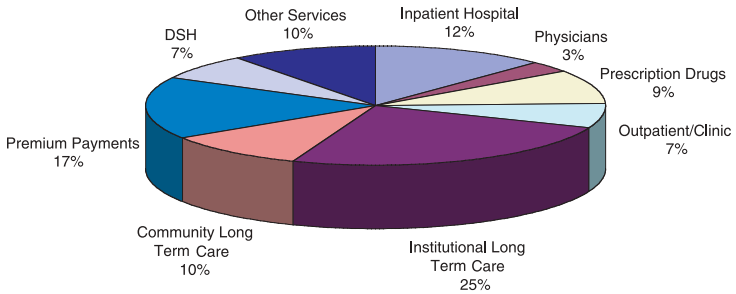
Medicaid is the largest single source of payment for health care services for persons with Acquired Immune Deficiency Syndrome (AIDS). Medicaid now serves over 50 percent of all AIDS patients and pays for the health care costs of most of the children and infants with AIDS. Medicaid spending for AIDS care and treatment in FY 2001 is estimated to be about $6.5 billion. In addition, the Medicaid programs of all 50 States and the District of Columbia provide coverage of all drugs approved by the Food and Drug Administration for treatment of AIDS.

## Payments

Under Medicaid, State payments for both medical assistance payments (MAP) and administrative (ADM) costs are matched with Federal funds. In FY 2001, State and Federal ADM gross outlays were $11.2 billion—almost 5 percent of the gross Medicaid outlays. State and Federal MAP gross outlays were $217.3 billion or 95 percent of total Medicaid outlays, an increase of nearly 11 percent over FY 2000. Section 802 of the Medicare, Medicaid, and State Children's Health Insurance Program (SCHIP) Benefits Improvement and Protection Act (BIPA), gave authority to transfer Federal Title XXI appropriations to

**Medicaid Medical Assistance Payments**
**FY 2001**

**Total Payments = $220 billion**

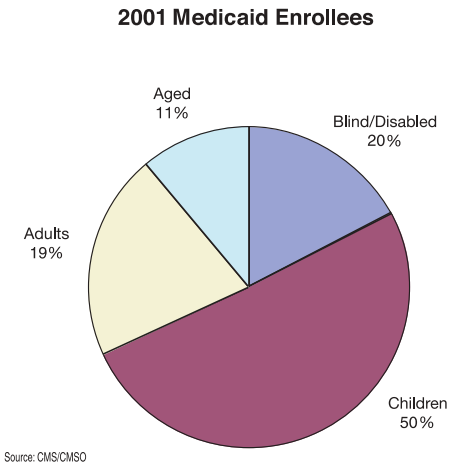



Source: CMS/CMSO

Title XIX as reimbursement for Medicaid expansion SCHIP (M-SCHIP) expenditures previously funded by Title XIX. In FY 2001, a Federal reimbursement of $1.2 billion from Title XXI to Title XIX for M-SCHIP resulted in State and Federal MAP and ADM net outlays of $227.3 billion. CMS's share of Medicaid expenses totaled $130.2 billion.

## Enrollees

About 34 million persons were enrolled in Medicaid in 2001. Children comprise 50 percent of Medicaid enrollees, but account for only 16 percent of Medicaid outlays. In contrast, the elderly and disabled comprise 31 percent of Medicaid enrollees, but accounted for 67 percent of program spending. The elderly and disabled use more expensive services in all categories, particularly nursing home services.




## Service Delivery Options

Many States are pursuing managed care as an alternative to the FFS system for their Medicaid programs. Managed health care provides several advantages for Medicaid beneficiaries, such as enhanced continuity of care, improved preventive care, and prevention of duplicative and contradictory treatments and/or medications. Most States have taken advantage of waivers provided by CMS to introduce managed care plans tailored to their State and local needs, and 48 States currently offer a form of managed care. The number of Medicaid beneficiaries enrolled in managed care has grown from slightly under 15 percent in 1993 to 56 percent by 2001.

CMS and the States have worked in partnership to offer managed care to Medicaid beneficiaries. Moreover, as a result of the BBA, States may amend their State plan to require certain Medicaid beneficiaries in their State to enroll in a managed care program, such as a managed care organization or primary care case manager. Medicaid law provides for three kinds of waivers of existing Federal statutes to allow for the implementation of managed care:

1) State health reform waivers—Section 1115 of the Social Security Act provides broad discretion to waive certain provisions of Medicaid law for experimental, pilot, or demonstration projects. In August 2001, the President announced a Section 1115 initiative, known as Health Insurance Flexibility and Accountability, to promote additional coverage of the uninsured.

2) Freedom of choice waivers—Section 1915(b) of the Social Security Act allows certain provisions of Medicaid law to be waived to allow States to develop innovative managed health care delivery or reimbursement systems.

3) State plan exceptions—Section 1932 (a) of the Social Security Act allows States to mandate managed care enrollment for certain groups of Medicaid beneficiaries. States may elect to include the Program of All-Inclusive Care for the Elderly (PACE) as a State plan option. PACE is a prepaid, capitated plan that provides comprehensive health care services to frail, older adults in the community, who are eligible for nursing homes according to State standards.

## State Children's Health Insurance

The State Children's Health Insurance Program (SCHIP) was created through the BBA to address the fact that nearly 11 million American children—one in seven—were uninsured and therefore at increased risk for preventable health problems. Many of these children were in working families that earned too little to afford private insurance on their own, but too much to be eligible for Medicaid. Congress and the Administration agreed to set aside $24 billion over five years, beginning in FY 1998, to create SCHIP—the largest health care investment in children since the creation of Medicaid in 1965. These funds cover the cost of insurance, reasonable costs for administration, and outreach services to get children enrolled. To make sure that funds are used to cover as many children as possible, funds must be used to cover previously uninsured children, and not to replace existing public or private coverage. Important cost-sharing protections were also established so families would not be burdened with out-of-pocket expenses they could not afford.

The statute sets the broad outlines of the program's structure, and establishes a partnership between the Federal and State governments. States are given broad flexibility in tailoring programs to meet their own circumstances. States can create or expand their own separate insurance programs, expand Medicaid, or combine both approaches. States can choose among benchmark benefit packages, develop a benefit package that is actuarially equivalent to one of the benchmark plans, use the Medicaid benefit package, or a combination of these approaches.

States also have the opportunity to set eligibility criteria regarding age, income, and residency within broad Federal guidelines. The Federal role is to ensure that State programs meet statutory requirements that are designed to ensure meaningful coverage under the program.

CMS works closely with States, Congress, the Health Resources and Services Administration, and other Federal agencies to meet the challenge of implementing this program and defining its parameters, while at the same time approving State plan amendments as quickly as possible. CMS provides extensive guidance and interim instructions so States can further develop their plans and use Federal funds to insure as many children as possible. Since September 30, 1999, all 50 States, the District of Columbia, and the Territories had approved child health plans. Of these, 21 are Medicaid expansions, 16 are separate State Child Health plans, and 19 are combination plans. In

addition, 91 amendments have been approved and five Section 1115 waivers have been approved that provide SCHIP funds to States to cover pregnant women and parents of children enrolled in Medicaid or SCHIP.

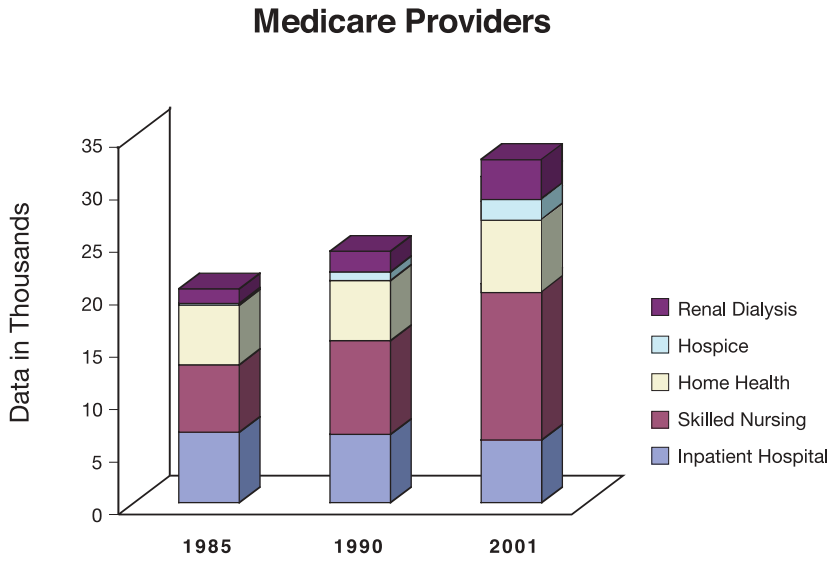
## Other Activities

In addition to making health care payments on behalf of our beneficiaries, CMS makes other important contributions to the delivery of health care in the United States.

### *Survey and Certification Program*

CMS is responsible for assuring the safety and quality of medical facilities, laboratories, providers, and suppliers by setting standards, conducting inspections, certifying providers as eligible for program payments, and ensuring that corrective actions are taken where deficiencies are found. The Survey and Certification program is designed to ensure that providers and suppliers comply with Federal health, safety, and program standards. CMS administers agreements with State survey agencies to conduct onsite facility inspections. Funding is provided through the Program Management and the Medicaid appropriations. Only certified providers, suppliers, and laboratories are eligible for Medicare or Medicaid payments.

There has been an overwhelming growth in facilities with the largest increases in skilled nursing facilities, home health agencies, hospices, and end-stage renal dialysis facilities. Certified Medicare providers in these types of facilities have increased from about 20,000 in FY 1985 to nearly 34,000 today.




Souce: CMS/OIS

## Clinical Laboratory Improvement Program

The Clinical Laboratory Improvement Amendments of 1988 (CLIA), expanded survey and certification of clinical laboratories from Medicare-participating and interstate commerce laboratories to all facilities testing specimens from the human body. CMS regulates all laboratory testing (whether provided to beneficiaries of CMS programs or to others) including those in physicians' offices. CMS, in partnership with the States, certifies and inspects approximately 13,500 laboratories each year. The CLIA program is a 100 percent user-fee financed program. The CLIA program is jointly operated by three HHS agencies: 1) CMS provides financial management of the program, contracts with surveyors to inspect labs, and offers general administrative support, 2) The Centers for Disease Control and Prevention (CDC) provides research support; and 3) The Food and Drug Administration (FDA) oversees test categorization.

## Quality of Care

Through PROs, ESRD Networks, State agencies, and others, CMS collaborates with health care providers and suppliers to promote the improved health status of Medicare and Medicaid beneficiaries in both FFS and managed care settings. These collaborative projects often employ a sequential process that includes setting priorities, collecting and analyzing data, identifying opportunities to improve care, establishing performance expectations, and selecting and managing one or more improvement strategies. One of the tools for improving patient care is the development and dissemination of quality indicators and the publication of performance information.

In addition, our provider conditions of participation or coverage are moving towards outcome-based measures. CMS continues to believe that providers must ensure that there is an effective quality-assurance program to evaluate the provisions of patient care. As a result, all provider conditions of participation or coverage are being updated to assure that providers have a demonstrated organizational commitment to provide and improve upon the quality of care to beneficiaries. These entities should measure, analyze, and track quality indicators, including adverse patient events or other aspects of performance that reflect processes of care and program operations.

## Coverage Policy

In today's health care market, every insurer and health care purchaser must deal with coverage policy. CMS established a new process that provides up-to-date information on coverage issues on the CMS coverage web site and also facilitates input from all stakeholders, including beneficiaries, through the Medicare Coverage Advisory Committee (MCAC). The MCAC holds open meetings and includes consumer and industry members. We also rely on state-of-the-art technology assessment and support from other Federal agencies, as well as considerable staff expertise.

Medicare is a leader in evidence-based decision making for coverage policy. Our own extensive payment data contain additional useful information that is used by the

Agency for Healthcare Research and Quality (AHRQ) and others for assessing the effectiveness of a variety of medical treatments.

### *Insurance Oversight*

CMS has primary responsibility for setting standards for the Medigap insurance offered to Medicare beneficiaries to help pay the coinsurance and deductibles that Medicare does not cover. CMS works with State insurance commissioners' offices to ensure that suspected violations of the laws governing the marketing and sales of Medigap are addressed.

CMS is also responsible for implementing the data standards provision of HIPAA. The administrative simplification provision is aimed at reducing administrative costs and burdens in the health care industry. It requires HHS to adopt national uniform standards for the electronic transmission of certain health information. CMS is working with both public and private organizations to develop the best standards possible with strong safeguards to ensure privacy of records. Although HIPAA does not mandate the collection or electronic transmission of any health information, it does require that adopted standards be used for any electronic transmission of specified transactions.

As a result of the insurance reform provisions of HIPAA, CMS has assumed a new role in relationship to State regulation of health insurance and health coverage. CMS works with the State Insurance Commissioners offices, the U.S. Department of Labor, and the Internal Revenue Service to implement these provisions. The common goal is to improve access to the group and individual health insurance markets for certain eligible individuals who move from job to job, or who lose their group health insurance coverage and must purchase coverage in the individual insurance market. These new consumer protections affect an estimated 160 million individuals.

# PERFORMANCE GOALS

Our performance goals reflect our mission and vision. Our mission is to assure health care security for beneficiaries. Health care security means access to affordable and quality health care services, protection of the rights and dignity of beneficiaries, and provision of clear and useful information to beneficiaries and providers to assist them in making health care decisions. Our vision is to lead the Nation's health care system toward improved health for all, in the stewardship of our programs. This vision reflects our commitment that all individuals will be given an unconditional assurance of having the same opportunity to have their health care needs met, regardless of location, income or other circumstances, and the quality of health care they receive is the best that can be provided.

The Government Performance and Results Act (GPRA) of 1993 requires Federal agencies to prepare 5-year strategic plans setting out long-term goals and objectives, Annual Performance Plans (APP) committing to short-term performance goals, and Annual Performance Reports (APR) explaining and documenting how effective the Agency's actions have been at achieving the stated goals.

Our performance measurement approach is based on two principles: (1) the most important things to measure relate to ensuring that CMS's beneficiaries receive the high quality care they need; and (2) the measures will be representative of program performance.

The APP describes CMS's performance goals, their linkage to longer-term strategic goals and to the budget, as well as the steps planned and underway to accomplish each goal. The plan also establishes a method and data source for measuring and reporting on each goal. The FY 2001 performance plan includes over 30 significant performance goals for CMS programs designed to provide coverage of major program areas and budget categories.

All CMS performance goals relate to important outcomes such as improved beneficiary health and satisfaction, sound fiscal management of one of the largest budgets in the Federal government, and maximum use of appropriate technology to improve service, increase productivity, and minimize cost. The plan contains performance goals relating to improved use of information technology, effective implementation of M+C and other provisions of the BBA, reduction in fraud and erroneous Medicare payments, and improvements in quality of care oversight and customer service. It reflects key Administration and Agency priorities for the next several years. Our performance goals reflect a sensitivity to customer needs and an awareness that meeting those needs will require flexibility and imagination, as well as sound business sense. The progress CMS has made on each of these FY 2001 performance goals will be submitted with the APR along with the President's budget request.

Consistent with GPRA principles, CMS identified a set of meaningful, outcome-oriented performance goals that speak to fundamental program purposes and to the Agency's role as stewards of billions of taxpayer dollars. The Agency is confident that performance measurement under GPRA will contribute substantially to improvement in CMS's programmatic and administrative performance. Performance results provide constructive information about the success of CMS's programs, activities, and initiatives. This information is useful in making policy and management choices in both the short and long term. The following section features 31 of the performance goals and outcomes organized by each of CMS's strategic goals. Performance goals that did not appear in this section last year are noted by an asterisk (*).

## Strategic Goal 1
## Protect and Improve Beneficiary Health and Satisfaction

**Improve access to care for the elderly and disabled Medicare beneficiaries who do not have public or private supplemental insurance.**

This performance goal focuses on reducing financial barriers to care by increasing the number of individuals who are dually qualified for Medicare and at least some aspects of the Medicaid program. Our emphasis in the initial years of this goal was on increasing enrollment for Medicare beneficiaries eligible for the Qualified Medicare

Beneficiary or the Specified Low-Income Medicare Beneficiary programs. We surpassed our FY 2000 target and increased enrollment in dual eligible programs by 4.4 percent. Due to the overwhelming success of so many States in FY 2000, we modified our approach to measuring this area for FY 2001. Instead of setting a goal to achieve a national rate increase of 4 percent, we are focusing on States that received CMS grants for outreach activities and States that did not meet the FY 2000 national target.

Interim FY 2001 data indicate States are making progress in adding enrollees. Additionally, CMS implemented a strategy for increasing enrollment of dual eligible populations that was established as part of the FY 1999 performance plan that called for an increase in partnerships with a variety of public and private agencies.

**Improve heart attack survival rates.**

This nationwide multi-year effort focuses on implementing known successful interventions for properly treating heart attacks and preventing subsequent heart attacks. Our target is to increase the 1-year survival rate following hospitalization for a heart attack by decreasing the mortality rate by 1 percentage point over 5 years to 27.4 percent. The most recent data from 1998–1999 shows a mortality rate of 32.3 percent, which is up from the 1995–1996 baseline of 31.2 percent. This may be attributable to several factors including that our efforts in this area has been phased in gradually; there may have been a change in concomitant diseases; and the age distribution of the Medicare population has increased, which could require risk adjustment. Analyses are underway to try to determine the effect of these factors and to modify the goal accordingly. The final data for this goal is not expected until FY 2003.

**Increase the percentage of Medicare beneficiaries age 65 years and older who receive an influenza (flu) vaccination and a lifetime vaccination for pneumococcal pneumonia.**

Complications arising from influenza and pneumococcal disease kill more than 20,000 people a year in the United States, resulting in more deaths per year than for all other vaccine-preventable diseases combined. For all persons age 65 or older, the Advisory Committee on Immunization Practices and other leading authorities recommend an annual vaccination for influenza and a lifetime vaccination for pneumococcal pneumonia.

Beginning in FY 2001, our goal to increase annual flu vaccinations for the elderly was expanded to include the receipt of a lifetime vaccination for pneumococcal pneumonia. Also, the Medicare Current Beneficiary Survey is used to track this goal in order to include institutionalized Medicare beneficiaries. Our FY 2001 target is to increase annual influenza vaccination rates to 72 percent and lifetime pneumococcal vaccination rates to 63 percent. The 1994 baselines were 59 percent for flu and 24.6 percent for pneumococcal pneumonia.

The effects of the FY 2000 shortage of flu vaccine and delayed immunizations remain to be seen, and the Centers for Disease Control and Prevention (CDC) predict shortages and delays in the FY 2001 flu season. The inability to quantify the impact of

these shortages reduces the confidence we have in achieving our targets for the affected years and for reliably setting future targets for adult immunizations.

We are still awaiting final data for our FY 2000 goal to increase flu vaccination rates to 60 percent based on the National Health Interview Survey (NHIS) data source.

**Increase the percentage of Medicare beneficiaries age 65 years and older receiving a biennial mammogram.**

A mammogram is a safe, low-dose x-ray of the breast and is the most effective means of detecting breast cancer while it is still in an early, treatable stage. Since older women face a greater risk of developing breast cancer than younger women, CMS's efforts to encourage regular mammograms is critical to reducing breast cancer among women of Medicare age.

Beginning in FY 2001, the data source used to measure this goal will be the Medicare National Claims History File, which will allow us to include our institutionalized populations in our measurement. Our goal for FY 2001 is to increase biennial mammography rates for women from the baseline rate of 45 percent (1997–1998) to 51 percent by the end of FY 2001. Interim data of 50.5 percent from 1999–2000 show that we are making excellent progress on this goal. We expect final data for this goal in August 2002.

We are still awaiting final data for our FY 2000 goal to increase biennial mammography rates to 60 percent based on the NHIS data source.

***Increase the rate of diabetic eye exams.**

Diabetes is another highly prevalent condition in the Medicare population and many complications of the disease, such as blindness, can be prevented or delayed with appropriate monitoring or treatment. This goal is to increase special eye exams given biennially for our diabetic beneficiaries in order to prevent a form of blindness associated with this disease. The baseline of the percentage of Medicare beneficiaries who received a diabetic eye exam from the Medicare National Claims History File is 67.8 percent (revised) (1997–1999) and our FY 2001 target is 68.3 percent. Although final data for this goal is expected in the Spring of 2002, we show good progress for the 1998–2000 interval, having achieved a rate of 68.1 percent.

**Decrease the number of uninsured children by working with States to implement the State Children's Health Insurance Program and by enrolling children in Medicaid.**

The BBA of 1997 created the SCHIP. This program makes an unprecedented investment toward improving the quality of life for millions of vulnerable, uninsured, low-income children. States were given the option to expand their Medicaid program, establish a separate SCHIP, or a combination of both. Our goal is to increase the number of children (up to age 19 for SCHIP; age 21 for Medicaid) who are enrolled in regular Medicaid or SCHIP by one million over the previous year's level. As of FY 2000, there were approximately 23,659,000 children enrolled in SCHIP and Medicaid, which

exceeded our FY 2000 target. Due to the overwhelming support for the program, we anticipate continued success for our goal to increase enrollment by 1 million in FY 2001. We expect final FY 2001 data in early calendar year (CY) 2002.

**Increase the percentage of Medicaid 2-year old children who are fully immunized.**

Three groups of States, staggered over 4 years, will develop State-specific baselines, methods and 3-year targets to increase childhood immunization rates for their States' Medicaid 2-year olds. In FY 2001, CMS continued its successful facilitation of this process from FY 2000 by sponsoring meetings, site visits, and providing ongoing technical assistance.

In FY 2001, the first group of States is expected to report their first remeasurement of State-specific immunization rates; the second group of States will have successfully completed the development of their measurement methods and set baseline and 3-year targets; and the third group of States began defining their State-specific methodologies and are on course to set baselines and targets by the end of FY 2002.

## Strategic Goal 2
## Promote the Fiscal Integrity of CMS Programs and be an Accountable Steward of Public Funds

**Improve CMS's rating on financial statements.**

As an Agency with one of the largest budgets in the Federal government, CMS has a special obligation to ensure that we spend each dollar, whether for benefits or administration, as wisely as possible. In both FY 1999 and FY 2000, CMS received an unqualified audit opinion. We are pleased to report that CMS has continued to meet its target of obtaining an unqualified opinion on the FY 2001 financial statements.

**Reduce the percentage of improper payments made under the Medicare fee-for-service program.**

The purpose of this goal is to continue to reduce the percentage of improper payments made under the Medicare FFS program. One of CMS's key goals is to pay claims properly the first time. This means paying the right amount to legitimate providers, for covered, reasonable, and necessary services provided to eligible beneficiaries. Paying claims right the first time saves resources required to recover improper payments and ensures the proper expenditure of valuable Medicare Trust Fund dollars. CMS has virtually cut the Medicare FFS error rate in half over the past few years. We met our FY 2000 goal by achieving a Medicare FFS error rate of 6.8 percent. We continued this successful trend of reducing the error rate by achieving a 6.3 percent level in FY 2001.

**Increase Medicare Secondary Payer credit balance recoveries and decrease recovery time to recoup dollar recoveries.**

Medicare Secondary Payer (MSP) activities ensure that payment for health care services for beneficiaries is made by the appropriate payer. The MSP activity attempts to collect timely and accurate information on the proper order of payers and ensure that Medicare pays only for those claims where it has primary responsibility. In FY 2001, we concentrated on the mandatory Medicare credit balance reporting requirements. The intent of these requirements is to ensure that Medicare properly recovers improper or excess program payments resulting from patient billing or claims processing errors. CMS has successfully met its FY 2001 target of gathering information on (1) credit balance identification, submission, and resolution processes; and (2) Medicare contractor monitoring and resolution of credit balances.

***Develop and implement methods for measuring program integrity outcomes.**

CMS is developing better methods to measure fraud, waste and abuse in the Medicare program. For FY 2001, CMS implemented a provider compliance rate (PCR) to measure the appropriateness of claims submitted prior to payments. In addition, CMS developed a Comprehensive Error Rate Testing (CERT) program that will produce contractor, provider, and benefit specific error rates. These error rates can be aggregated to produce national level estimates similar to the Medicare FFS error rate, but with greater precision. Both PCR and CERT are being implemented simultaneously in three phases at Durable Medical Equipment Regional Carriers, and carriers on the VIPS Medicare System (VMS) and Electronic Data System/Medicare Contractor System. All other contractors are expected to implement PCR and CERT no later than October 2002.

***Improve the effectiveness of program integrity activities through the successful implementation of the Comprehensive Plan for Program Integrity.**

This goal was designed to monitor the implementation and measure the effectiveness of CMS's Comprehensive Plan for Program Integrity. CMS has evaluated various initiatives in order to target high risk areas and better focus our resources to address problem areas. While performance is being assessed throughout the implementation process, it has been critical to monitor the overall effectiveness of each initiative in the plan throughout FY 2001. Data for several of the initiatives will not be available until 2002. We expect to meet the targets for this goal.

***Assist States in conducting Medicaid payment accuracy studies for the purpose of measuring and ultimately reducing Medicaid payment error rates.**

CMS is committed to assisting interested States in developing methodologies and conducting pilot studies to reduce Medicaid payment error rates. The FY 2001 target was to work with two States to conduct payment accuracy studies. The data from these studies would be used to help refine payment accuracy measurement methodologies and assess the feasibility of constructing a single methodology usable by all States.

We did not meet our FY 2001 target due to delays in securing the necessary funding and formally recruiting pilot States. By the end of the year, however, we received and approved the applications of nine States to conduct pilot studies in FY 2002.

## Strategic Goal 3
## Purchase the Best Value Health Care for Beneficiaries

**Decrease the prevalence of restraints in nursing homes.**

Achieving low prevalence of physical restraint use is an accepted indicator of quality of care, and considered a proxy for measuring quality of life for nursing home residents. The use of restraints can cause incontinence, pressure sores, loss of mobility, and other morbidities. We met the FY 2000 target to decrease physical restraints to 10 percent. The FY 2001 target is to maintain the prevalence of restraints in nursing homes to no more than 10 percent. Final data is expected in March 2002.

**Decrease the prevalence of pressure ulcers in nursing homes.**

CMS sponsors several pressure ulcer reduction initiatives: a satellite broadcast education program, enhancing methods of surveyor detection of pressure ulcers using minimum data set and quality indicator reports, and more detailed guidance to surveyors to detect pressure ulcer assessment and treatment deficiencies. We met the FY 2000 target to establish a baseline, set targets, and identify additional interventions to decrease the prevalence of pressure ulcers. The FY 2001 target is to decrease the prevalence of pressure ulcers in nursing homes to 9.6 percent. Final data is expected in March 2002.

***Improve the management of the survey and certification budget development and execution process.**

Our goal to improve the survey and certification budget process moved CMS from the "cost" based approach to a "price" based methodology, which uses national standard measures of workload and costs to project individual State workloads and budgets. We analyzed the combined national average survey times for long term care facilities. Any State that exceeded the combined national average survey time for long term care facilities by 15 percent or more was provided an FY 2001 base budget that assumed the FY 2000 funding level. All other States received a FY 2001 base budget increase that did not exceed regional office State budget recommendations.

We met our FY 2001 target to allocate the FY 2001 budget increase to the State survey and certification budget using a price-based methodology. Survey quality performance measures to enhance the survey process were communicated to regional offices and States in FY 2001.

# Strategic Goal 4
# Promote Beneficiary and Public Understanding of CMS and its Programs

***Improve beneficiary understanding of basic features of the Medicare program.**

We place a high priority on educating our beneficiaries with critical information about Medicare program options and provisions. This performance goal and the following goal involving the National Medicare & You Education Program measure our efforts to educate Medicare beneficiaries. We expect to yield positive results for both of these goals through the following CMS efforts: 2001 Fall Medicare Education Campaign, expanded phone service availability for 1-800-MEDICARE, expanded web-based capabilities to help consumers compare health plan choices, and a publicity campaign on the new choices and new ways to obtain information.

Our goal is to improve beneficiary awareness of (1) the core features of the Medicare program and (2) CMS sources available for additional information. We completed all our targeted actions necessary to design and field survey questions to measure our efforts in these areas, the results of which should be known in early calendar year 2002. At that time, we will set specific targets based on our baseline information.

**Improve effectiveness of dissemination of Medicare information to beneficiaries through the National Medicare & You Education Program.**

With clear baselines in place, we are tracking efforts of the National Medicare & You Education Program toward our 5-year target for beneficiary accessibility and understanding of educational efforts regarding the M+C program. Our goal is that by FY 2004, 77 percent of beneficiaries (a 10 percent increase over FY 1999) will report that the information they received answered their questions and 57 percent (also a 10 percent increase over FY 1999) will know that most people covered by Medicare can select from among different health plan options within Medicare.

**Improve effectiveness of dissemination of Medicare information to beneficiaries in fee-for-service through implementation of the Medicare Summary Notice.**

National implementation of the Medicare Summary Notice (MSN) is expected to improve effectiveness of information for beneficiaries enrolled in the FFS program. Because this monthly information will be in a more understandable, clear format than previous multiple notices, it is also expected to be easier for beneficiaries to spot inconsistencies or instances of potential fraud. Our target is to support MSN efforts aiming toward full implementation in FY 2002. In FY 2000 and FY 2001, we supported the Medicare contractors that have already implemented the MSN by providing technical assistance on implementation issues. Carrier/fiscal intermediary implementation is at 81 percent. We also continue to handle in a timely manner all Congressional, beneficiary, contractor, and beneficiary advocacy group inquiries relating to the MSN and to address

the confusion that beneficiaries may feel due to receiving the MSN in some instances and different benefit notices in other instances.

***Improve Medicare's administration of the beneficiary appeal process.**

The appeal process is a critical safeguard available to all Medicare beneficiaries, allowing them to challenge denial of service. To improve the appeal process, we plan to collect data on internal appeal activity from M+C Organizations. We will analyze this information to understand more about the number and type of appeals filed by beneficiaries and the disposition of the appeals. In FY 2001, CMS released an Operational Policy Letter to inform the M+C Organizations of this process that partially fulfilled this goal. The collection of data, however, has been delayed due to concerns regarding burdening plans with increased reporting requirements. This same concern delayed implementation to begin data collection in FY 2000.

## Strategic Goal 5
## Foster Excellence in the Design and Administration of CMS's Programs

**Enroll beneficiaries into managed care plans timely.**

While encouraging our beneficiaries to choose the health plan best suited for their needs, we want to ensure timely enrollment into managed care with no interruption in health care delivery or payment. The managed care organizations were unfamiliar with the new enrollment timeframes. Also the data extraction technique included some inappropriate transactions in the counts, resulting in the percentages being lower than they actually should have been. As a result, we fell short of our FY 1999 target. The managed care organizations have since gained experience with the new enrollment timeframes, and the extraction technique has been improved to provide more accurate data. Thus, in FY 2000 and FY 2001, we have met and exceeded our target of enrolling 98 percent of our beneficiaries into managed care plans timely.

**Sustain Medicare payment timeliness consistent with statutory floor and ceiling requirements.**

We will continue to maintain payment timeliness performance at a level that meets the statutory requirement of Medicare intermediaries and carriers paying 95 percent of clean electronic media claims between 14 and 30 days from the date of receipt. We exceeded our FY 2000 target (intermediaries equal 99.4 percent; carriers equal 99.6 percent). Final data for FY 2001 will be available in early CY 2002.

**Improve CMS's information systems security.**

As CMS broadens the scope of its systems security program with increased numbers of business partners and technological complexity, the protection of confidential information becomes even more critical. We are fully committed to fulfilling our

stewardship responsibilities for the information contained in our data systems and transported across our networks.

In FYs 2000 and 2001, during a period when audit activity was increasing, CMS's goal remained steadfast, i.e., to achieve zero material weaknesses in the electronic data processing (EDP) portion of the FY 2000 and 2001 CFO audits. One material weakness was identified in FY 2000, and corrective action was taken. The results for FY 2001 will be available in FY 2002. In addition, 95 percent of CMS employees were to receive security training. A majority of the employees are to receive this training through a computer-based training package that is nearing availability for use. A percentage of this goal was achieved through security conferences and awareness training held at CMS. The last part of the goal, to complete site security reviews for Medicare payment contractors, has been met. Medicare contractor reviews are now being carried out through the Statement of Auditing Standard (SAS)-70 reviews and the CFO audit.

**Develop and implement an information technology architecture.**

As required by the Clinger-Cohen Act of 1996, we are developing an integrated, enterprise-wide Information Technology (IT) architecture that is aligned with our strategic business objectives. The IT architecture will document the relationships between CMS's business and management processes. Its purpose is to ensure that IT requirements are aligned with the business processes that support our mission; and that a logically consistent set of policies and standards is developed to guide the engineering of our IT systems. CMS's Chief Information Officer has overall responsibility for the IT architecture, and has appointed an architect to oversee its development and implementation. In FY 2000, all basic service areas were approved with policies being addressed as needed. Work began in FY 2001 to meet our goal to develop standard configuration templates for use in major design efforts. We expect to complete our work by Spring 2002. A second target—to integrate the IT architecture Conformance Criteria into the IT Investment Review Process—has been met.

**Increase the use of electronic commerce/standards in Medicare.**

CMS is performing ongoing work with the HIPAA electronic standards development for the health care environment. In FY 2001, we began implementing HIPAA Electronic Data Interchange standards. CMS is consulting with Medicare technical staff (within CMS and the Medicare contractor community) to develop a baseline and target date. Programming and preliminary testing for implementation of the HIPAA claim standard was completed in FY 2001. As a result of changes in Agency project prioritization, programming hours and funding were unavailable for this project in FY 2001 to enable completion of implementation and testing for each of the HIPAA standards. In addition, due to the complexity of implementation of these standards, contractor programming hour estimates increased resulting in completion of less work. We met our FY 2000 and 2001 targets of maintaining Electronic Media Claim levels of 97 percent for intermediaries and 80 percent for carriers.

**Develop new Medicare payment systems in fee-for-service and Medicare + Choice.**

This goal was designed to measure our progress towards the development of additional payment systems in FFS and M+C. We achieved our FY 2000 goal of implementing the hospital outpatient department prospective payment system (PPS) and risk adjusted payments under M+C. We also published the home health agency PPS final rule. We met our FY 2001 goal of implementing a PPS for home health agencies and risk adjusting payments to managed care plans.

***Improve CMS oversight of Medicare fee-for-service contractors.**

Medicare FFS contractors are paid to process claims and administer benefit outlays. They also handle appeals; respond to inquiries from providers and beneficiaries; enroll, educate and train providers and suppliers; educate and assist beneficiaries; and perform other responsibilities on behalf of CMS. In an effort to improve performance and oversight of these contractors, CMS has established several performance objectives in this area. Through the use of performance information to guide our contractor oversight activities, we are looking forward to continued improvement. Better oversight can be obtained by using a standardized, uniform evaluation process, which is under development. In FY 2001, CMS continued to build on its progress in developing this goal.

## Strategic Goal 6
## Provide Leadership in the Broader Public Interest to Improve Health

**Ensure compliance with HIPAA requirements through the use of policy form reviews.**

Our FY 2001 goal to ensure compliance with HIPAA access, portability, and renewability requirements measures our progress towards reviewing insurance policy forms in those States that (1) do not guarantee renewal of insurance coverage, (2) have not passed appropriate laws, or (3) do not substantially enforce them. These reviews determine if the contractual wording of the forms discloses certain protections mandated by HIPAA. We met our FY 2000 and FY 2001 targets of ensuring 30 percent and 60 percent compliance, respectively. We continue to enforce amendments to HIPAA in several States.

**Provide to States linked Medicare and Medicaid data files for dually eligible beneficiaries.**

This goal was designed to provide a complete picture of Medicare and Medicaid service utilization and expenditures. Individuals who are dually eligible for Medicare and Medicaid are an important and growing segment of beneficiaries. Although dually eligible beneficiaries represent about 15 percent of the Medicare population, they account for 30 percent of total Medicare expenditures. We met our FY 2000 target by making Medicare utilization data available to 50 States and 6 Territories. We met our goal for FY 2001 to provide States with all linked identifiers for those who are dually eligible and make readily accessible supporting Medicare utilization data.

**Assess the relationship between CMS research investments and program improvements.**

The purpose of our research program is to provide CMS and the health care policy community with objective analyses and information to develop, test and implement new health care financing policies as well as evaluate the impact of CMS's programs on its beneficiaries, providers, States and other customers and partners. A regular systematic review and assessment of our research program is important to ensure that CMS's beneficiaries obtain maximum benefits from research and development spending. Our performance on this goal is measured using a formal annual internal assessment that is reviewed and evaluated by external experts. We did not conduct an external review in FY 2000, but elected to postpone the initial external review pending refinement of the internal review process. We did, however, meet our goal in FY 2001, completing both the internal and external assessments.

***Sustain improved laboratory testing accuracy.**

The CLIA strengthened quality performance requirements under the Public Health Service Act and extended requirements for all laboratories that test specimens from the human body. Under CLIA, CMS will continue its partnership with the States to certify and inspect laboratories that test specimens from the human body. Our performance goal is to sustain improved laboratory testing accuracy by having 90 percent of laboratories enrolled in proficiency testing with no failures and having 95 percent of laboratories enrolled and participating in proficiency testing. In CY 2000, CMS exceeded its targets. We expect to receive CY 2001 data in the first quarter of CY 2002, and based on interim performance data, we anticipate continued success.

# INITIATIVES

## Program Integrity Strategy

CMS has implemented proactive measures to reduce fraud, waste, and abuse in the Medicare program. Increased funding, as well as new contracting authority allowing the Agency to contract with new private entities for program integrity services, enabled CMS to begin innovative approaches to program integrity. These new approaches have provided CMS with the tools necessary to reduce the FFS payment error rate by more than half since 1996, from 14 percent in FY 1996 to 6.3 percent in FY 2001.

Our current program integrity strategy is two-pronged. We direct our efforts to broad educational initiatives to assist providers in submitting claims that will be paid right the first time. At the same time, we remain vigilant in our oversight of claims payment through data driven statistical analyses designed to stem fraud, waste, and abuse. This strategy enables us to deploy our resources along three broad fronts:

- Increasing the focus of Agency and its claims processing contractors on provider education as a means to decrease errors.
- Identifying emerging vulnerabilities that have the biggest impact on our programs and targeting the appropriate medical review, audit or fraud investigation resources to address them.
- Continuing our partnership with law enforcement, through the Health Care Fraud and Abuse Control program, and supporting law enforcement's efforts to prosecute and convict those who commit health care crimes.

While we have made definite progress in our efforts to ensure proper payment, we must continue our vigilance and oversight of the Medicare program. Particular areas of focus include:

- Continuing efforts to reduce the error rate as we strive to achieve our 2002 GPRA goal of a 5 percent FFS payment error rate.
- Maintaining a focus on statistical measurement as a means of identifying and correcting payment errors.
- Continuing and enhancing the Agency's provider education efforts.
- Continuing our work—in partnership with law enforcement—to identify, halt, and discipline those who would use the program for illegal gain.

## Strategies to Reduce the Error and Fraud Rates

Our primary goal is to reduce the CFO audit Medicare FFS payment error rate to 5 percent by 2002. The rate is now at 6.3 percent. We are developing methods to help us focus our efforts and resources to reduce payment error rates. The Comprehensive Error Rate Testing (CERT) program will produce a paid claims error rate at each contractor, by provider type and service category levels. The Provider Compliance Rate (PCR) will provide an estimate of the accuracy of claims submitted by providers.

## The Medicare Integrity Program

As a result of HIPAA, which established the Medicare Integrity Program (MIP), CMS can now competitively award contracts to entities to promote the integrity of the Medicare program. The competitive process ensures best value for the Government from both a quality and price perspective and further allows the Government to contract with entities that not only have program integrity experience, but who also offer new and innovative solutions and diverse areas of expertise. These specialized contractors will increase efficiency and effectiveness, and consistency in application of Medicare coverage and coding rules. Establishing organizations that focus on program safeguard activities separate from the mainstream of claims processing operations is a solution to a potential conflict of interest and a prudent business practice. To date, CMS has established two types of MIP contractors, the Coordination of Benefits contractor—first established in FY 2000 to ensure that Medicare pays the appropriate amount when a

beneficiary has other insurance coverage—and the Program Safeguard Contractors (PSCs). In 1999 CMS awarded MIP contracts to twelve PSCs that perform some, all, or any sub-set of the work associated with the following program integrity activities: medical review, cost report audit, data analysis, provider education, and fraud detection and prevention.

### Payment Error Prevention Program

The PROs' main goals are to improve quality of care for beneficiaries by ensuring that care meets professionally recognized standards, to protect the integrity of the Medicare program, and to protect beneficiaries through investigation of individual complaints and outreach and education activities.

Under the 3-year contracts that began in August 1999, CMS has directed the PROs to increase their focus on ensuring Medicare hospital inpatient claims are billed and paid appropriately. As part of the Comprehensive Plan for Program Integrity, the PROs' Payment Error Prevention Program (PEPP) is focused at acute care hospitals operating under the Prospective Payment System. The PROs are budgeted to spend about 24 percent of their efforts on PEPP.

The CMS developed a monitoring system to estimate the FFS payment error rate independently within each State or PRO area. This monitoring system is continuous in nature and is designed to produce periodic estimates. The PROs are required to conduct analyses to identify the nature and extent of payment errors occurring in their area. On the basis of their analysis, the PROs implement appropriate educational interventions aimed at changing provider behavior and decreasing the observed payment error rate.

The incentives for PEPP will be an award bonus paid at the end of the contract period. It is based upon the reduction in payment error observed in each PRO area. The overall target for the 3-year contract period is a 50 percent reduction in the payment error rate. The target will be adjusted for each PRO using the baseline payment error rate found in each State. As the data have contractual implications for each PRO's upcoming performance evaluation, the final results are not yet available for general publication.

## Working with our Partners

### Medicare Fee-for-Service Contractors

Medicare FFS contractors play an important partnership role with CMS in administering the Medicare program and safeguarding the fiscal integrity of the Medicare Trust Funds. We assess contractor performance through the Contractor Performance Evaluation (CPE) process with a goal of determining the extent to which contractors administer the Medicare program efficiently and economically, and meet their contractual obligations as required by law, regulation, contract, and CMS directive.

We contracted with a consulting firm to assist us in establishing a continuous improvement process for all aspects of CPE. With their assistance, we identified best

practices and lessons learned from FY 2000 CPE reviews, and held Lessons Learned conferences in January 2001 to share this information with regional and central office staff involved in the CPE process. The consulting firm also documented and analyzed the entire CPE process and developed recommendations for improvements to the process. We are analyzing these recommendations to incorporate into future CPE activities.

In addition, a number of changes have been made to the CPE process to further enhance the effectiveness and consistency of the oversight of Medicare FFS contractors. The FY 2001 CPE plan was built on prior initiatives by employing risk analysis to prioritize contractors for review; developing and requiring the use of 15 standard functional area review protocols by all evaluators; and providing more prescriptive direction and training for reviewers on the planning, conduct, and reporting of CPE reviews. To further enhance the consistency of our evaluation activities, we increased the number of review teams comprised of central office and regional office staff to evaluate a broader array of business functions at a greater number of contractor locations.

FY 2001 was the first year CPE was done for provider inquiries. As a result of the information gained, we were able to set Budget Performance Requirement standards relevant to provider calls and change the Quality Call Monitoring process to put a greater emphasis on the accuracy of the information provided.

The review teams conducted the following onsite reviews of critical business functions at higher risk contractors:

- Medical review, Medicare Secondary Payer, provider enrollment, provider education and training, benefits integrity, customer service, appeals, provider audit, provider reimbursement, accounts receivable, change management, and overpayments were evaluated at selected fiscal intermediaries;
- Medical review, Medicare Secondary Payer, provider enrollment, benefits integrity, customer service, appeals, accounts receivable, change management, and overpayments were evaluated at selected carriers; and
- Fraud and abuse, quality, efficiency, and service were evaluated at the four Durable Medical Equipment Regional Carriers.

We performed evaluations of certain other business functions at all FFS contractors doing business with CMS in FY 2001. The functional areas included mandated claims processing, customer service, payment safeguard standards, administrative budget desk reviews, and internal control reviews performed by independent public accounting firms at 13 contractors.

In addition, CMS conducted performance improvement plan follow-up reviews to verify correction of deficiencies identified in prior year CPE activities, as well as corrective action plan reviews to follow-up on findings resulting from CMS's FY 2000 CFO audit.

We further streamlined our CPE tracking and reporting process by contracting with a consulting firm in FY 2001 to develop an intranet-based national CPE database to capture

relevant CPE statistics and to simplify and standardize the CPE report management report preparation process. This database was implemented for the FY 2001 review cycle and is being successfully used by CPE project leaders and reviewers.

In addition, CMS is developing a strategic multi-year business plan for Medicare FFS contractor operations. This is an important component for improving the management of Medicare contractors and strengthening CMS's business partnership relationship with these contractors. This plan also supports future innovation in the Medicare program, such as changes in Medicare benefits and new delivery or payment structures.

## Medicaid Initiatives

As part of the National Medicaid Fraud and Abuse Initiative, CMS will continue to assist the OIG, the State Medicaid Fraud Control Units, and Program Integrity Units in their role of identifying and sanctioning fraudulent providers. We ensure that all States are aware of fraudulent activities and scams occurring nationwide; promote consistency by establishing enhanced communications systems; form a National Fraud and Abuse Technical Advisory Group composed of CMS and State agencies; and develop a model legislative fraud and abuse package for States that builds on the best practices of States who already have similar legislation. CMS has also placed greater emphasis on Medicaid fraud through formation of the Medicaid Fraud and Abuse Coordinating Council and the Medicaid Regional Office Network.

## Partnering with States to Regulate Health Insurance

HIPAA provides for, among other things, improved portability and continuity of health insurance coverage in the group and individual insurance markets. The law provides for shared responsibilities for the Secretaries of HHS, Labor, and Treasury. HHS, through CMS, is working with the other Departments in implementing the group market provisions. In addition, CMS has the sole responsibility for implementing and overseeing the provision of insurance protection in the individual market, and with respect to nonfederal government plans.

The group market provisions of HIPAA affect group health plans. These HIPAA provisions are designed to improve the availability and portability of health coverage by limiting exclusions for preexisting conditions; providing credit for prior health coverage; providing new rights that allow some individuals to enroll for health coverage when they lose other coverage or have a dependent; prohibiting discrimination in enrollment and premiums; and guaranteeing availability of health insurance coverage for small employers and renewability of coverage in both the small and large group markets.

We issued twelve bulletins to clarify several issues, including insurers being prohibited from imposing nonconfinement clauses on eligible individuals; who qualifies as an "eligible individual" for purposes of obtaining health insurance coverage in the individual market; the relationship of certain types of State laws to the application of the guaranteed availability requirements of HIPAA; and the relationship between State "succeeding carrier" laws and the issuer's obligation under HIPAA to enroll an eligible

individual who is hospitalized. Additionally, CMS has helped hundreds of consumers resolve their HIPAA-related issues and exercise their rights under the statute.

To implement and enforce HIPAA provisions, CMS collects and reviews documentation regarding policy forms for compliance, regulates certificates of prior creditable coverage, and monitors marketing of individual policies. We have been working closely with State officials so that workers and their families in these States can benefit from this law as soon as possible.

## Improving the Health of Beneficiaries

### *Coverage*

One of CMS's greatest challenges in administering the Medicare program is to maintain a dynamic decision making process that produces consistent coverage guidance in the face of rapid changes in medical technology and health care delivery. We are committed to continuing to improve our open, understandable and predictable coverage process to further strengthen access to medical advances for Medicare beneficiaries, while protecting them from services whose effectiveness is unproven.

Medicare has emerged as a leader in the move towards evidence-based decision making for coverage policy. We rely on state-of-the-art technology assessment and on agencies, such as the Agency for Healthcare Research and Quality, the Food and Drug Administration, the National Institutes of Health, the Department of Veterans Affairs, the Department of Defense as well as the advice of the medical community and private sector studies. Our own extensive Medicare and Medicaid data contain additional useful information for assessing the effectiveness of all varieties of medical care. The experiences of the Medicare program can benefit the entire health care marketplace.

Medicare continues to develop and implement payment policies that are now being used in the private sector. This is in part due to the number of beneficiaries that we serve and the wealth of information available. Examples include prospective payment for inpatient hospitals, home health agencies and skilled nursing facilities, and the resource-based relative-value system for physician payment.

We have chartered an advisory committee that, when requested, advises CMS on national coverage issues. It holds open meetings and provides an opportunity for public participation on coverage issues referred to the committee. The committee is divided into small, clinically focused panels comprised of nationally recognized experts in a broad range of medical, scientific, and professional disciplines, as well as representatives of consumer and industry groups. The committee reviews and evaluates medical literature, reviews technical assessments, and examines data and information on the effectiveness and appropriateness of medical items and services. Based on the evidence, the committee advises and makes recommendations to CMS regarding coverage issues.

## Health Promotion and Prevention

We are continuing our collaboration with the National Cancer Institute on a joint outreach campaign entitled "Not Just Once, But for a Lifetime," which aims to increase awareness of older women's risk for breast cancer and the importance of regular mammograms. A key goal of the campaign is to increase the number of women with Medicare who take advantage of the yearly screening benefit. Asian-American women are a specific target audience because they have the lowest rates of early detection screening for breast cancer. Materials for this audience are being produced in Chinese, Tagalog, and Vietnamese.

## ESRD Initiatives

As the single largest purchaser of ESRD treatment services in the United States, CMS has a critical responsibility for the quality of care delivered to these patients. Our challenge is to improve the quality and accessibility of the services, while keeping an eye on costs.

Additionally, we realize the need for collaboration between CMS, the ESRD Networks, the State survey agencies, National Institutes of Health, United States Renal Data System, United Network for Organ Sharing, and the renal community to develop a data management and analysis initiative, which will support quality measurement, as well as better monitoring management of patients with kidney failure. This initiative includes the development of a larger, more comprehensive database in a central repository that will be accessible and linked to CMS and ESRD Network databases. Users will be able to access financial and clinical data on all Medicare beneficiaries with kidney failure.

We have successfully completed another year of data collection and reporting by the ESRD Clinical Performance Measures Project (formerly known as the ESRD Core Indicator Project). We are building a comprehensive, integrated approach to the quality management process for ESRD on a number of fronts. We are implementing a focused survey process, revising the Conditions for Coverage, developing ESRD clinical performance measures on quality of care, and enhancing the quality improvement projects of the ESRD Networks.

We are also working to respond to comprehensive reports from the OIG and the General Accounting Office, as well as continuing interest from the Senate Special Committee on Aging on a wide variety of ESRD issues. These issues include using the new conditions to hold individual dialysis facilities more accountable for the care they provide, using existing enforcement authority more effectively, and making facility-specific data more available to consumers.

As part of the effort to educate consumers, CMS created a publication for people with kidney failure who are new to the Medicare program. This guide was designed in conjunction with the ESRD Networks and extensively consumer tested with people being treated for kidney failure. The guide provides accurate and reliable information on the disease, treatment options, patient resources, Medicare ESRD benefits, the grievances process, and role of ESRD Networks and State agencies. We also initiated our

Dialysis Facility Compare web site, **www.medicare.gov**, which includes information for the public regarding the quality of care and survival rates in over 3,500 dialysis units. The web site also allows beneficiaries to order free publications online, as well as from our 1-800-MEDICARE (1-800-633-4227) toll-free telephone line.

To strengthen and continue our partnership with the ESRD community, we have initiated ESRD "Listening Sessions." Listening Sessions are open forums that allow representatives of the ESRD provider community, professional associations, and patient advocacy groups to share their views with CMS leadership on a wide variety of topics, including new reimbursement initiatives, new conditions for coverage, daily dialysis, new technology, and new methods for providing care. The first Listening Session was held on November 13, 2001, and these productive exchanges of ideas will continue on a regular basis.

## Organ Donation Activities

We designed several activities in FY 2001 to promote the Secretary's initiative to increase organ and tissue donation. Some examples include:

- Our four regional consortia Organ Procurement Organization (OPO) coordinators engaged in a variety of activities designed to increase organ donation, including annual OPO site visits; presentations at local and national conferences; serving on organ donation task forces; training State surveyors; and sponsoring bone marrow donation initiatives.
- We received and analyzed the results of a Harvard School of Public Health study of a methodology for estimating the number of potential donors in hospitals. We also met several times with representatives from the Association of Organ Procurement Organizations (AOPO) to discuss and analyze their methodology for estimating the number of potential donors in hospitals.
- Based on analysis of the Harvard and AOPO methodologies and additional input from AOPO, CMS has developed new performance measures for OPOs.
- A new regulation with process and outcome performance standards for OPOs was published on December 31, 2001.
- Health Resources and Services Administration (HRSA), CMS, AOPO, and the United Network for Organ Sharing (UNOS) have developed a system for OPOs to report hospital-specific organ donation data to UNOS, HRSA, and CMS. The data will be used to monitor implementation of the hospital condition of participation for organ, tissue, and eye donation.

## Asthma Activities

We have been working with States to assure that Medicaid beneficiaries with asthma, particularly children, receive appropriate care. The increasing incidence of asthma and its prevalence among low-income populations makes this an important issue for Medicaid. The Medicaid program covers asthma-related medical services, including physician services, supplies, prescription drugs, and services of other licensed

practitioners. Some State Medicaid programs have developed disease management programs and are coordinating asthma-related initiatives with other programs.

## Breast and Cervical Cancer

For the past ten years, the Centers for Disease Control and Prevention's (CDC) National Breast and Cervical Cancer Early Detection Program (NBCCEDP) has provided screening exams to underserved women, including women with low incomes and women of racial and ethnic minority groups. New legislation gives States the option to provide medical assistance through Medicaid to eligible women who are screened through the NBCCEDP and found to have breast or cervical cancer, including pre-cancerous conditions. As of September 20, 2001, 19 States have approved plan amendments, and seven States are awaiting State plan amendment approval for this new option.

## Smoking Cessation

We have been working with States on the updated Public Health Service (PHS) Clinical Practice Guideline related to tobacco use and the possible implications for Medicaid coverage of smoking cessation drug therapy and counseling programs. States have the option to cover prescription and certain non-prescription smoking cessation drugs for Medicaid beneficiaries. About half of the State Medicaid programs cover some type of smoking cessation drug therapy and about a fifth of the States cover smoking cessation counseling. State Medicaid agencies are encouraged to consider the benefits of promoting smoking cessation, and we recommend that they provide coverage for smoking cessation drug therapy and counseling to all Medicaid beneficiaries. State Medicaid agencies must ensure that such services are available to pregnant women and children as appropriate for individuals under 21 as part of the Early and Periodic Screening, Diagnostic, and Treatment component of Medicaid.

## Nursing Home Oversight Improvement Program

The Nursing Home Oversight Improvement Program provides enhanced protections for nursing home residents. It targets needed improvements in nursing home quality through a number of enhancements to the survey and monitoring process. Changes to the survey process emphasize care areas such as nutrition, hydration, pressure sores, unnecessary drugs, and better interventions to prevent neglect and abuse in nursing homes. The initiative also calls for more frequent inspections of facilities that repeatedly violate standards, as well as staggered inspections on weekends and evenings to ensure uniformity in the quality of care. We continue to raise awareness about detecting and reporting neglect and abuse in nursing homes through partnerships with resident advocacy groups and professional nursing home organizations. CMS and representatives of these groups designed a nursing home abuse awareness poster with a "take action" message. The poster is targeted at residents of nursing homes, family members, and the nursing home caregivers. Certified Nursing Assistants are being targeted to increase their awareness of the symptoms of malnutrition and dehydration and the action steps they can take to correct the situation.

## Hospital Quality Oversight

In response to the recommendations of the Office of Inspector General's report (The External Review of Hospital Quality Oversight—A Call for Greater Accountability), CMS continues to improve the oversight and quality of care in hospitals participating in the Medicare and Medicaid programs. Our initiative is designed to improve the accountability of accrediting organizations, the meaningfulness of survey information, and the systems for data collection and information sharing. Accomplishing this has included collaborating with the major accrediting agencies such as the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and the American Osteopathic Association (AOA), as well as with State agencies. In FY 2001, CMS published a Notice of Proposed Rule Making on Certified Registered Nurse Anesthetist Supervision requirements and submitted the Quality Assessment and Performance Improvement (QAPI) final rule for HHS clearance.

## The Quality Improvement System for Managed Care (QISMC)

The QISMC provides a coordinated, data-driven quality improvement and oversight system for Medicare and Medicaid beneficiaries. As a part of the quality improvement system, M+C Organizations are required to report on Health Plan Employer Data Information Sets (HEDIS) and Consumer Assessment of Health Plans Study (CAHPS) measures for purposes of comparative reporting to Medicare beneficiaries, address patient rights issues, and undertake Quality Assessment and Performance Improvement (QAPI) projects. The QAPI project for 2001 focused on congestive heart failure. The national QAPI project for 2002 will be breast cancer screening and 2003 will be cultural and linguistically appropriate services.

## Clinical Trials Initiative

Clinical trials are research studies designed to evaluate the safety and effectiveness of medical care. They are key to understanding the appropriate use of medical interventions of all types and informing payers about what services to cover. Previously, Medicare has not paid for items and services related to clinical trials because of their experimental nature. As a result, only a very small percentage of American seniors participate in clinical trials, although the elderly bear a disproportionate burden of disease in the United States.

On September 19, 2000, CMS implemented a National Coverage Decision authorizing Medicare coverage of the routine costs of qualifying clinical trials as well as reasonable and necessary items and services used to diagnose and treat complications arising from participation in all clinical trials.

In addition, an information brochure ***Medicare and Clinical Trials*** was developed and published in January 2001.

# Educating Beneficiaries for Value-Based Decision Making

## Defining Beneficiary Needs

The Medicare Current Beneficiary Survey (MCBS) helps in monitoring, evaluating, and responding to the health care needs of Medicare beneficiaries. It is a comprehensive source of information on health care, socioeconomic, and demographic and other characteristics of aged, disabled, and institutional Medicare beneficiaries. It directly involves beneficiaries in defining their health care needs by interviewing a large representative sample of them about their health status and physical functioning, access to care, and satisfaction with the Medicare services they use. The MCBS aids in CMS's educational and outreach initiatives by collecting information to determine which methods are best suited to reach specific subgroups of the Medicare population, and what the communication preferences are for the general Medicare population and several specific subgroups. The section of questions specific to beneficiary information initiatives has been refined. These data help evaluate and continuously improve Agency communication activities.

In addition, CMS is continuing the market research initiative. The inventory work of documenting beneficiary information needs and communication preferences for the general Medicare population and several specific subgroups has been completed. Reports of results are available. Also, consumer product testing is conducted on written beneficiary documents and we continue to obtain beneficiary input during the development of Agency programs and products. Finally, the Agency has a consumer research and communications contract with four prime contractors that can conduct the full range of communications activities.

## The CMS Web Sites

CMS data bases are the largest and most complete source of health care information in the United States. The CMS Internet web site, **www.hcfa.gov**, contains a wealth of information on Medicare, Medicaid, SCHIP, and HIPAA, and serves as an information clearinghouse for CMS publications and information. However, the Agency's new web site **www.cms.hhs.gov** went live on September 13, 2001. Initially the site serves as an introductory page to CMS and all other Agency sites. We are working toward consolidating all external web sites into this single unified Internet presence that contains authoritative, accurate, and up-to-date information. Although some beneficiaries do not have access to the Internet, beneficiary and consumer advocates, insurance counselors, and public entities, who are the most frequent sources of beneficiary advice and counseling, do possess this technology.

The **www.medicare.gov** web site is the Government site for people with Medicare, and is one of the keystones of CMS's multifaceted beneficiary-centered public information program that has been designed to improve the quality of health care. Its target audience includes Medicare beneficiaries, caregivers, and advocacy groups. The

site has evolved into an elaborate wealth of information, which is supported by a variety of interactive databases.

Several enhancements have been added to the site in FY 2001. The "Beneficiary Outreach Calendar" allows a user to search for details about local events, health fairs, or educational meetings. "Medigap Compare" enables users to find private health insurance plans that can be purchased to supplement Medicare. "Participating Physician Directory" includes the name, specialty, and location of Medicare participating providers. "Prescription Drug Assistance Program Compare" contains information on Medigap plans that offer some prescription drug coverage, State pharmacy assistance programs, pharmaceutical company assistance programs, programs sponsored by organizations for specific diseases/conditions, and community-based programs. "Dialysis Facility Compare" includes descriptive information and quality measures such as survival rates and adequacy of dialysis for most Medicare-certified dialysis facilities in the country.

Additional services are now available or are being added to the web site: A "screen reader version" that helps people with visual impairments to use the site; "Listserv" to automatically notify subscribers of site changes; a "print easy" feature allowing consumers to print all pages within each section without links and extraneous text; "Medicare Health Plan Compare" available in Spanish including all the quality and disenrollment information; and online ordering of publications.

Also the **www.hcfa.gov/medlearn** web site is the Internet gateway to all of the educational information, products, and services that are created by CMS and its contractors. The MedLearn web site allows Medicare providers to quickly obtain information they need to successfully navigate the Medicare program. This web site includes quick reference guides, manuals, instructions, frequently asked questions, fact sheets, and other pertinent information.

## *National Medicare & You Education Program*

The National Medicare & You Education Program was implemented in 1998 under the name National Medicare Education Program, and used several channels to reach beneficiaries with accurate, consistent information on their health plan options, the basic Medicare program, beneficiary rights and protections, as well as issues of local concern such as plan terminations. The strategy included direct mail of the ***Medicare & You 2001*** handbook to all beneficiary households, a national toll-free assistance line, 1-800-MEDICARE (1-800-633-4227), and the **www.medicare.gov** beneficiary web site. Last fall we launched a national advertising "I am Medicare" campaign that included television, radio, and print ads as part of our Medicare education initiative that will make it easier for Medicare beneficiaries to learn about their choices and become informed participants. The campaign achieved Public Service Announcement placement in all 50 States and Washington, D.C. with confirmed participation by more than 300 print and radio outlets. The 1-800-MEDICARE toll-free line was significantly expanded to provide even better customer service to callers. The 1-800-MEDICARE Call Centers now operate 24 hours a day, seven days a week. At any time, callers can speak

directly with a Customer Service Representative (CSR) to discuss their Medicare issues. The Regional Education About Choices in Health (REACH) Campaign, a nationally coordinated outreach campaign consisting of close to 2,000 localized activities, was carried out by CMS's regional offices. More than 3,000 outreach activities were held nationwide in FY 2000 as part of the REACH campaign to increase awareness of M+C and Medicare issues.

Grants were also provided to 53 State Health Insurance Assistance Programs to support a counseling and assistance network of nearly 1,000 community level programs with over 12,000 volunteer counselors. These community level programs impact 2.7 million beneficiaries annually—1.4 million through one-on-one counseling and 1.3 million through 30,000 local educational events. The grantees include all 50 States and the District of Columbia, Puerto Rico, and the Virgin Islands.

## Annual Publications

In FY 2001, the ***Medicare & You 2001*** handbook was mailed monthly to a total of 240,000 newly eligible Medicare beneficiaries. In addition, during the annual Fall mailing, ***Medicare & You 2002*** was mailed to 34 million beneficiary households nationwide. The handbook provides beneficiaries with information about Medicare and their health plan choices, and is available in Spanish, and a variety of alternate formats, including audiotape (English and Spanish), large print (English and Spanish), and braille.

As a result of a court order in *Gray Panthers vs. Tommy Thompson*, CMS was also required to develop and mail 26 area specific booklets ***Medicare+Choice Local Plan Information*** containing local plan comparison information to 27 million beneficiary households by October 15, 2001.

CMS and the National Association of Insurance Commissioners (NAIC) jointly developed and published the ***2001 Guide to Health Insurance for People with Medicare: Choosing a Medigap Policy***, which provides detailed information on buying and using a Medigap policy. This Guide is available in Spanish, and a variety of alternate formats, including audiotape (English and Spanish), large print (English and Spanish), and braille.

Many other publications were revised or introduced in FY 2001, including the following: ***Medicare Preventive Services; Your Medicare Benefits; Medicare Savings Program; Medigap Policies: The Basics; Dialysis Facility Compare; Choosing a Medicare Health Plan; Choosing Long Term Care; Publications Catalog; Health Coverage Directory for People with Medicare; New Rules for Switching Medicare Health Plans; Where to Get Your Medicare Questions Answered;*** and ***Women with Medicare: Visiting Your Doctor for a Pap Test, Pelvic Exam and Clinical Breast Exam***. Most are available in Spanish, and some in alternate formats. We also produced seven publications in Chinese.

### Activities to Assist in Value-Based Purchasing

We continue to require contracted managed care organizations to submit quality measures from the Medicare HEDIS report to the NCQA each year. These measures included effectiveness of care, use of services, access to care, and other areas where we thought it important for CMS, as the largest purchaser of health care, to have a better understanding of the performance of Medicare managed care plans. There were 302 HEDIS reports in 2000, and 206 HEDIS reports in 2001. The declining volume of HEDIS reports is caused by contract non-renewals and contract consolidations.

We intend to combine HEDIS measures with other information that CMS collects about health plans, such as beneficiary satisfaction, physician reimbursement arrangements, and disenrollment. Additionally, HBG and HPG have developed an MCQ monitoring tool, which uses HEDIS data from the past four years. The tool and monitoring procedure will be presented to industry and implemented by CMS regional offices by January 2002. For Medicaid, the States have the option of using those HEDIS measures that are most appropriate for their populations. We are also exploring the feasibility of calculating selected effectiveness of care measures for its FFS population.

## Electronic Data Processing

### Standardizing Systems

To become a more effective administrator of Medicare, our goal is to continue to work towards consolidating the Medicare payment systems into three standard systems, one for fiscal intermediaries, one for carriers and one for durable medical equipment carriers. This will simplify operations, enable us to implement more effective change control processes, and ensure that the highest priority changes are made first. Consolidation of the durable medical equipment system was completed and the transitions to the selected system accomplished at four carriers.

### Information Systems Security

Our business needs and information technology are changing the way we do business. We have an ever-expanding set of partners and customers; we want to conduct business more quickly using state-of-the-art communications; and we have a presence on the Internet and wish to leverage its capabilities in efficient and secure ways. This environment presents new opportunities, as well as new information systems security risks that CMS must manage. We recognize that, with CMS's missions increasingly dependent on information, a strong systems security infrastructure is essential to increased efficacy. A CMS security program has been initiated and encompasses all aspects of information systems security: policy, administration, training, engineering, and oversight. The program establishes a framework to develop and implement policies, procedures and controls to comply with systems security requirements. Additionally, CMS is partnering with HHS and others to identify security standards appropriate for the evolving technological environment.

### *Information Technology Management Process*

In accordance with the Clinger-Cohen Act of 1996, CMS developed a formal IT investment management process. This process focuses on the selection, control, and evaluation of all IT projects, ensuring that they are implemented at acceptable costs, within reasonable time frames, and are contributing to tangible, observable improvements in mission performance. In conjunction with the IT investment management process, CMS has established a project review process for major IT investments. The process ensures that IT projects are developed consistent with the Agency's IT architecture standards (business, applications, infrastructure, information, security, and governing policies and procedures). The process will promote effective workload management (enterprise scheduling and resource planning) for internal, external, and contractor resources required to deploy the IT application and/or system; and provide project owners with a clearly-defined process and a central focal point for involving IT professionals in the development of the project technical solutions. The HIGLAS project is the first financial system to be initiated under the IT investment management process.

# FINANCIAL ACCOMPLISHMENTS AND STATEMENT HIGHLIGHTS

Since the first Chief Financial Officer (CFO) audit of CMS's financial statements, our goals have been to achieve an unqualified opinion or "clean opinion" from the auditors indicating that CMS's financial statements are fairly presented in all material respects and to improve our internal controls and systems. Over the past several years, we have made tremendous strides in these endeavors as indicated by the clean audit opinion we received, for the third consecutive year, on the FY 2001 financial statements.

As an agency with one of the largest budgets in the Federal government, we recognize that we have a special obligation to ensure that each dollar we spend, whether for benefits or administration, is spent as wisely as possible. Therefore, CMS's financial management operations are an integral aspect of CMS's program and administrative activities. In this regard, CMS's strategic vision for financial management is simple and direct: To develop and maintain a strong financial management operation to meet the changing requirements and challenges of the twenty-first century as we continue to safeguard the assets of the Medicare Trust Funds. To accomplish this vision, we must improve financial reporting and contractor oversight to ensure reliable and accurate financial information is available to CMS management and other decision makers. All of the financial management initiatives, projects, and activities we have identified are focused on meeting this challenge.

## Chief Financial Officer Comprehensive Plan and Project Plans

For FY 2000, CMS noted the accomplishment of issuing the first ***Chief Financial Officer Comprehensive Plan for Financial Management***, which provided "a clear statement against which progress can be measured." The Comprehensive Plan supports CMS's strategic vision by outlining all of the activities we believe are necessary to ensure that we meet our responsibilities to our nation's citizens in establishing a strong and effective financial operation at CMS. It contains 10 goals that are supported by 25 initiatives for achieving our strategic vision. The four key financial management objectives of our plan are to: (1) improve financial reporting, guidance, and oversight by providing timely, reliable, and accurate financial information that will enable CMS managers and other decision makers to make timely and accurate program and administrative decisions; (2) design and implement effective management systems that comply with the Federal Financial Management Improvement Act (FFMIA); (3) improve debt collection and internal accounting operations; and (4) validate key financial data to ensure its accuracy and reliability.

To assist both in measuring the progress and in achieving the goals and initiatives in the comprehensive plan, for FY 2001 CMS issued the ***Chief Financial Officer Fiscal Year 2001 Project Plans***. The project plans identified the milestones for achieving the Comprehensive Plan goals and initiatives, as well as the detailed activities that led up to the milestones. Each goal and initiative had a project leader, who reported on their progress monthly to the CFO and the Deputy CFO. Project management is essential to any successful business and CMS has endorsed project planning enthusiastically. Building on the proven accomplishments obtained in FY 2001, CMS will issue the ***Chief Financial Officer Fiscal Year 2002 Project Plans***.

## CFO Audit

We received our first clean audit opinion on our financial statements in FY 1999. While obtaining a clean opinion continues to be an important objective, we recognize that additional efforts are necessary to continue financial management improvements. We need to take steps that continuously improve internal controls and the underlying financial reporting processes to ensure that we can generate accurate financial data on an on-going and timely basis. Our auditors continue to have concerns over many aspects of contractor financial reporting. One of the major issues remaining is the status of accounts receivable, most of which are maintained on our behalf by our fiscal intermediaries (FI) and carriers. These organizations, commonly referred to as Medicare contractors, have contracted with CMS to administer the day-to-day operations of the Medicare program. They pay claims, audit provider cost reports, and establish and collect overpayments. Because the systems used by the Medicare contractors have not always produced data that were adequately supported, our auditors have had difficulty validating their accounts receivable balances.

## Accounts Receivable

To continue receiving a clean opinion, we recognize that our financial statements have to properly reflect accounts receivable at their true economic value based on provisions provided within the Office of Management and Budget Circular A-129, ***Managing Federal Credit Programs.*** Medicare accounts receivable consist primarily of provider and beneficiary overpayments, and Medicare Secondary Payer (MSP) receivables of paid claims that we subsequently determined that Medicare should have been the secondary rather than the primary payer.

While we have made progress and continue to make significant improvements in financial reporting, our auditors continue to report a material weakness in the Medicare accounts receivable area. Our long-term solution to addressing this material weakness is the implementation of the CMS Healthcare Integrated General Ledger Accounting System (HIGLAS) project. Until this project is implemented, CMS will continue ongoing projects and activities aimed at compensating for the lack of the modernized system.

### Revised Reporting Policy

During FY 2001, we undertook a major initiative in revising and issuing Medicare contractor financial reporting instructions. These instructions include policies regarding the definition of an accounts receivable; the treatment of unfiled cost reports and allowance for uncollectible accounts; recognizing and reporting non-MSP and MSP currently not collectible (CNC) debt. In addition, these revisions included the reformatting of financial reports to enable Medicare contractors, CMS central and regional offices to provide more detailed financial data.

We also continued to perform extensive analysis of our delinquent debt, focusing on the likelihood of collection and the write-off of uncollectible debts. In addition, CMS issued new policies on the reporting of delinquent debts to properly reflect accounts receivable balances at their true economic value. These policies provide for identification and write-off of old uncollectible MSP debt, as well as the referral of delinquent debt to debt collection centers under the Debt Collection Improvement Act of 1996.

### Adjustments to Previously Reported Receivables

In addition to revising policies, we used independent certified public accountants (CPAs) as consultants to review Medicare contractor accounts receivable balances in order to validate the receivable amounts reported to CMS and the adequacy of their internal controls. For FY 2001, the consultants conducted reviews at 12 Medicare contractors, which comprised about 82 percent of the accounts receivable balance reflected in last year's financial statements. Additionally, the scope of these reviews included the timely implementation of contractor corrective action plans (CAPs).

The consultants' reviews disclosed a total of $294 million non-MSP errors resulting in the accounts receivable being overstated by $240 million. While there is clearly room for improvement, these amounts indicate significant progress and reflect CMS's continuing commitment to generate accurate financial statements.

**Trend Analysis**

During FY 2001, CMS used consultants to assist us in developing analytical tools necessary to perform more expansive trend analysis of critical financial related data, specifically accounts receivable and semiannual financial statements. These tools provide us the steps necessary to identify unusual variances and potential areas of risk. Additionally, the tools allow CMS to readily perform more extensive data analyses, follow up with Medicare contractors, and determine the need for additional actions to ensure that problems are adequately resolved. These enhancements, along with additional staff members hired during FY 2000, allowed us to conduct trend analysis starting with the quarter ending June 30, 2000. During FY 2001, we issued instructions to CMS regional offices to perform trending analysis on their own accounts receivable data, starting with the quarter ending June 30, 2001.

### *Corrective Action Plans*

The annual CFO audits have assisted in identifying financial management and electronic data processing (EDP) weaknesses that limit our ability to effectively manage the Medicare and Medicaid programs. Correcting these deficiencies is critical if we are to demonstrate our commitment to improving financial management and internal controls. Therefore, audit resolution is a top priority at CMS. Medicare contractors, regional offices, and central office components are required to prepare a CAP for all deficiencies identified.

During FY 2001, CMS issued written standard operating policies and procedures for central and regional offices to follow in processing CAPs resulting from CFO audits, Statement on Auditing Standards (SAS)-70 reviews, as well as other financial management audits and reviews performed by consulting/CPA firms, the Office of Inspector General, and the General Accounting Office. All Medicare contractors that had audit findings in FY 2000 submitted a CAP and received comments from CMS regarding the adequacy of their submitted plan. In addition, CMS received quarterly updates to the CAP, which describe financial activities and efforts underway to correct prior year findings. During FY 2001, the consultants, central office, and regional office staff followed up on contractor CAPs during the accounts receivable Contractor Performance Evaluation (CPE) reviews. Regional office systems security staff visited Medicare contractors to ensure that EDP problems were corrected.

## Debt Collection

Historic collection data indicates that CMS collects the majority of its debt because most overpayments are recognized timely, thus allowing future claims to be offset against current overpayments. Debts that are not collected within 180 days are subject to the Debt Collection Improvement Act (DCIA). Under the DCIA, Federal agencies are required to refer debts to the Treasury Offset Program (TOP) and to a designated Debt Collection Center (DCC) for cross-servicing once they have become 180 days delinquent. Debts referred to the TOP are housed in the National Interactive Database and matched to Federal payments for potential offset. Debts referred to a DCC for cross-servicing can

have a variety of collection activities including sending additional demand letters, referring debts to the TOP, referring debts to private collection agencies, negotiating repayment agreements, and eventually referring some debts to the Department of Justice for litigation if necessary. The Department of Health and Human Services' Program Support Center (PSC) serves as the DCC for all MSP debts and a small portion of Non-MSP debts. The majority of Non-MSP debts are referred to Treasury, via the PSC, for cross-servicing and referral to TOP.

During FY 2001, CMS expanded the accelerated debt referral process to all Medicare contractors and CMS regional offices. The Medicare contractors and regional offices forwarded customized demand letters to the delinquent debtors and input the debt information into the Agency's Debt Collection System (DCS) to refer the debt electronically to the PSC and Treasury. As a result of the expansion of the debt referral process to all Medicare contractors and regional offices, CMS referred an additional $2.1 billion of delinquent debt in FY 2001 to the PSC and Treasury for cross-servicing and TOP. This brought the Agency's total delinquent debt referred to the PSC and Treasury to about $4 billion by the end of FY 2001. Our ultimate goal is to have 100 percent of our eligible delinquent debt referred for cross-servicing and TOP by the end of FY 2002.

## Financial Management & Reporting

One of the major benefits of the CFO Act has been to highlight the importance of accurate financial reporting and reliable internal controls. This has assisted us in identifying areas that need attention to ensure that we are presenting an accurate financial picture of CMS.

### *Budget Execution*

We continue to improve our budget execution for the Program Management Appropriation. The Financial Management Investment Board (FMIB) comprising senior staff representing each CMS component has been established to recommend allocations of resources in support of Agency priorities. Final operating plan allocations are made by the Agency's Deputy Administrator/Chief Operating Officer. In addition, we established lapse targets for each Program Management allotment, and managed funds aggressively to meet those targets. This ensured available funds were identified timely and allocated to fund Agency priorities.

### *Guidance to Medicare Contractors*

Medicare contractors provide much of the financial data CMS uses to manage the Medicare program. The importance of ensuring that they are effectively managing resources and reporting accurate financial data cannot be emphasized enough. Therefore, CMS continued its efforts to hold Medicare contractors accountable for improved financial management. To stress the importance of our commitment to improving financial management, we met with each contractor's CFO for Medicare Operations.

We also revised and clarified financial reporting and debt collection policies and procedures based on findings from CFO audits, oversight reviews, and Statement of Auditing Standards (SAS)–70 internal control reviews. The evaluation of findings resulting from these reviews allows us to perform risk analysis and profiling of Medicare contractors to determine where our resources should be focused and where additional guidance is needed. Our goal is to continue to improve the consistency of information provided by the Medicare contractors.

We conducted two national training conferences for all of the Medicare contractors and regional offices, with participation from contracted CPA firms. We presented our revised policies and procedures for financial reporting and also emphasized the importance of debt referral and documenting internal controls. With assurances that data is valid and complete, we have greater confidence in the accuracy and reliability of the financial information reported.

We also hired consultants to assist us in developing a Medicare contractor financial manual that will enhance contractors' ability to map their internal control environment and will assist CMS in the development of training on internal control requirements. To ensure that our instructions are readily available, we developed an Internet-accessible database, which contains all financial management guidance and instructions issued. Additionally, this information will be consolidated with other useful financial management information (such as the annual Financial Report, best practices, answers to frequently asked questions, and interim policy guidance) on a CFO web page that is in an initial stage of development. This web page will provide useful links to other financial web pages in the Federal Government.

## *Medicare Contractor Oversight*

Medicare contractors administer the day-to-day operations of the Medicare program by paying claims, auditing provider cost reports, and establishing and collecting overpayments. As part of these activities, Medicare contractors are required to maintain a vast array of financial data. Due to the materiality of this data, CMS must have assurances as to its validity and accuracy. Therefore, CMS established a number of initiatives that will improve the quality and consistency of financial data received from Medicare contractors. These initiatives are further enhanced by our trend analysis process.

### Internal Control Reviews: SAS-70 and CPIC

During FY 2001, we contracted with CPA firms to conduct SAS-70 internal control reviews of 13 Medicare contractors. The reviews indicated that 12 of 13 contractors reviewed had one or more exceptions. To ensure that the exceptions are properly addressed in a timely manner, CMS has requested that the contractors develop and submit CAPs. For FY 2002, reviews will be conducted at 4 Medicare contractors initially and additional Medicare contractors will be selected. This effort will concentrate on the functional areas of EDP, financial management, MSP, and debt collection. We require all Medicare contractors to submit an annual Certification Package for Internal Controls (CPIC) on their Medicare operations. In the CPIC, contractors are required to report their material weaknesses and

reportable conditions. We require CAPs for all material weaknesses reported in the CPICs. CPA firms also review the CPICs.

### Contractor Performance Evaluations (CPE) Program

As part of our CPE program, accounts receivable reviews were conducted at selected Medicare contractors. The purpose of these reviews was to ensure that the contractors have support and proper audit trails for accounts receivable data reported to CMS. These reviews were either conducted by a team comprised of multi-office staff or a national team of both central and regional office staff. Regardless of the type of team conducting the review, a standard review protocol was used to ensure the reviews are consistent. In addition, the contractors submitted Performance Improvement Plans or CAPs to address the findings identified.

In FY 2001, CMS contracted with consultant CPA firms to perform accounts receivable reviews at 12 contractors comprising 82 percent of the accounts receivable balance. The scope of the review also included contractor implementation of CAPs.

### CMS-1522 Reconciliations

The auditors continue to identify a material weakness in Medicare contractors' reconciliations of their CMS-1522 Funds Expended Reports to their paid claims tapes. Each month, contractors are required to submit this reconciliation to CMS. During FY 2001, a change request was issued to reiterate the policy on reconciliation requirements. Additionally, a centralized e-mail box was established to ensure the timely receipt of all 1522 reconciliations from the contractors. We also drafted a 1522 review protocol, which was tested by regional office teams at two contractor locations. The protocol will be finalized during early CY 2002 and a Pic-Tel training session will be scheduled.

## *Financial Reporting*

In FY 2001, we continued to improve our financial statement reporting process within CMS central office. During FY 2001, all financial data, including data provided by the Department of the Treasury and other Federal agencies, was included in CMS's general ledger. This facilitated the preparation of the financial statements by eliminating manual entries into spreadsheets to determine necessary adjustments. It also provided the auditors with a clearer audit trail.

We have continued the initiative of preparing automated formatted financial statements. The objective is to be able to produce and rely upon formatted financial statements directly from the Financial Accounting and Control System (FACS). This will enable the system to produce an audit trail documenting manual adjustments made to accounts that affect the financial statements. In FY 2001, we completed the automation of three principal financial statements. We expect to have automation of the two remaining principal statements completed in FY 2002. We also produced interim financial statements for the quarter ending June 30, 2001, and for the third consecutive year submitted our financial statements through the automated financial statement system implemented by the Department of Health and Human Services.

We have also complied with the Department of the Treasury's November 2001 reporting requirement for the Federal Agencies Centralized Trial Balance System (FACTS) II and the February 2001 reporting requirements for FACTS I. We also improved the operation of FACS by programming and successfully implementing 111 accounting enhancements. These changes ensured that we met new program and Treasury requirements, as well as improved our administrative and accounting operations.

## Medicare Secondary Payer

Our efforts in the MSP area are again projected to save the Medicare Trust Funds approximately $3 billion dollars. During FY 2001, CMS concentrated on increasing MSP dollar recoveries and/or decreasing recovery time. We continue to work with the Department of Justice to include repayments to the Medicare Trust Funds when a product liability suit is brought against a manufacturer. During FY 2000, CMS made progress toward the recovery of funds from voluntary medical device recalls and product liability litigation, such as Sulzer Hip Replacement, Bone Screw, Heart Valves, Breast Implants, and Fen-Phen.

We are achieving savings to the Medicare program by maintaining a comprehensive health care insurance profile on all Medicare beneficiaries that enables Medicare to pay the appropriate amount when the beneficiary has other insurance coverage. The maintenance of this insurance profile by a single Coordination of Benefits contractor will allow for cost reductions and management efficiencies by consolidating activities related to updating the insurance profile, which were formerly performed by 50 Medicare contractors.

## Other Initiatives

For the past several years, the number of unsettled managed care cost reports has been decreasing. However, reconciliation efforts detected an additional 105 cost reports not originally accounted for in the beginning inventory of unsettled managed care cost reports. As a result, at the close of FY 2001, the total backlog of unsettled managed care cost reports was 153, an increase of about 53 percent. Disallowances resulting from FY 2001 settlement activity amounted to about $42 million. Although we have historically experienced a rate of return of about 22 to 1, we anticipate those numbers decreasing in the future due to the rising cost of these audits. The remaining backlog of unsettled managed care cost reports will represent the greatest challenges to CMS, due to the fact these cost reports have the most audit issues that must be resolved with the managed care organizations. Therefore, it is projected that settlement activity will not remain at the heightened level it has been in the past several fiscal years.

We also made important accomplishments in our administrative payment areas as well. We continued to pay all of our administrative payments on time in accordance with the Prompt Payment Act. Over 99 percent of our vendor payments are paid electronically and 100 percent of travel and grant payments are paid electronically.

## Healthcare Integrated General Ledger Accounting System

The Federal Financial Management Improvement Act (FFMIA) of 1996 broadened coverage of the CFO Act to require agencies to implement and maintain financial management systems that comply with Federal financial management systems requirements as defined by the Joint Financial Management Improvement Program (JFMIP). The requirements of the FFMIA are also detailed in guidance from the Office of Management and Budget (OMB), specifically OMB Circular A-127 that requires Federal agencies to have an integrated financial management system. Although our CFO auditors have found that Medicare contractors' claims processing systems are operating effectively in paying claims, they were not designed to meet the requirements of a dual entry, general ledger accounting system. As a result, they do not meet the provisions of FFMIA.

Therefore, a key element of our strategic vision is to acquire a FFMIA-compliant financial management system that will include all Medicare contractors. This project is called the Healthcare Integrated General Ledger Accounting System (HIGLAS). As part of this effort, CMS will replace the FACS. FACS accumulates all of CMS's financial activities, both programmatic and administrative, in its general ledger.

OMB Circular A-130, ***Management of Federal Information Resources***, requires that financial management systems development and implementation efforts seek cost effective and efficient solutions. Agencies must consider the use of commercial-off-the-shelf (COTS) software as the preferred alternative to reduce costs, improve the efficiency and effectiveness of financial system improvement projects, and reduce the risks inherent in developing and implementing a new system. As such, CMS has acquired a COTS product for HIGLAS that has been certified by the JFMIP. On September 26, 2001, CMS awarded the HIGLAS contract to PricewaterhouseCoopers (PwC), whose major teaming partners include Oracle Corporation and Electronic Data Systems (EDS). PwC will act as the systems integrator, Oracle Corporation will provide the financial accounting software, and EDS will provide application service provider services.

Implementing an integrated general ledger program will give CMS enhanced oversight of contractor accounting systems and provide high quality, timely data for decision-making and performance measurement.

The project will begin with a pilot program with one Medicare contractor (Palmetto Government Benefit Administrators) that processes primarily hospital and other institutional claims, and another (Empire Blue Cross & Blue Shield) that processes primarily physician and supplier claims. The pilot phase will reengineer the accounting business process of the Medicare contractors to support the accounting software.

Once completed, the system will be thoroughly tested to ensure it works correctly and can handle the large volume of financial transactions generated by the Medicare program before a final decision is made to install the accounting system for Medicare and all its contractors. Full implementation is projected for the end of fiscal year 2006.

The new system will also strengthen Medicare's management of its accounts receivable and allow more timely and effective collection activities on outstanding debts. These improvements in financial reporting by CMS and its contractors are essential to retaining an unqualified opinion on CMS's financial statements, meeting the requirements of key federal legislation, and safeguarding government assets.

### Accounts Receivable Systems

Concurrent with the development of HIGLAS, CMS is developing two accounts receivable systems. The requirements for the Medicare Accounts Receivable System (MARS) have been subsumed as a part of the requirements for the accounts receivable module of HIGLAS, which will collect specific financial data relative to CMS's accounts receivable reported by central and regional offices and Medicare contractors. The accounts receivable module will also facilitate the preparation of the Treasury Report on Receivables, which is sent to the Department of the Treasury on a quarterly basis. The Recovery Management and Accounting System (ReMAS) will perform the developmental work to determine an MSP receivable. Once the debt has been identified as a receivable (for example, ready for a demand for repayment), it will be sent to HIGLAS for accounts receivable management.

## Financial Statement Highlights

### Consolidating Balance Sheet

The Consolidating Balance Sheet presents amounts of future economic benefits owned or managed by CMS (assets), amounts owed (liabilities), and amounts that comprise the difference (net position). CMS's Consolidating Balance Sheet shows $276.5 billion in assets. The bulk of these assets are in the Trust Fund Investments totaling $243.1 billion, which are invested in U.S. Treasury Special Issues, special public obligations for exclusive purchase by the Medicare Trust Funds. Trust Fund holdings not necessary to meet current expenditures are invested in interest-bearing obligations of the United States or in obligations guaranteed as to both principal and interest by the United States. The next largest asset is the Fund Balance with Treasury of $17.4 billion, most of which is for Medicaid and SCHIP. Liabilities of $41.4 billion consist primarily of the Entitlement Benefits Due and Payable of $40.4 billion. CMS's net position totals $235.1 billion and reflects the cumulative results of the Medicare Trust Fund investments and the unexpended balance for SCHIP.

### Consolidating Statement of Net Cost

In FY 2001, the Consolidating Statement of Net Cost shows only a single amount: the actual net cost of CMS's operations for the period by program. In prior year financial statements, earned revenues were deducted from expenses to arrive at the net cost of operations. The three major programs that CMS administers are Medicare, Medicaid, and SCHIP. The majority of CMS's expenses are allocated to these programs.

Total Benefit Payments were $372.5 billion for FY 2001. This amount includes estimated improper Medicare payments of $7.2 to $16.9 billion based on an audit by the Office of the Inspector General. Administrative Expenses were $2.4 billion, less than 1 percent of total net Program/Activity Costs of $352.4 billion.

The net cost of the Medicare program including benefit payments, Peer Review Organizations, Medicare Integrity Program spending, and administrative costs, was $219.4 billion. Hospital Insurance (HI) program costs of $142.3 billion were offset by $1.4 billion in premiums. Supplementary Medical Insurance (SMI) program costs of $100.8 billion were offset by premiums of $22.3 billion. Medicaid program costs of $130.5 billion represent expenses incurred by the States and Territories that were reimbursed by CMS during the fiscal year, plus accrued payables. Medicaid costs were offset by a $1.2 billion reimbursement from SCHIP to cover Medicaid's financing of the Medicaid Expansion SCHIP services from fiscal years 1998 through 2000. SCHIP program costs of $3.7 billion were offset by the $1.2 billion reimbursement to Medicaid, resulting in a net cost of $2.5 billion.

## Consolidating Statement of Changes in Net Position

The Consolidating Statement of Changes in Net Position shows the net cost of operations less financing sources other than exchange revenues, and the net position at the end of period. The line, Appropriations Used, represents the Medicaid appropriations used of $128.9 billion, $79.7 billion in transfers from Payments to Health Care Trust Funds to HI and SMI, SCHIP appropriations of $3.7 billion, and Ticket to Work appropriations of $3 million. Medicaid and SCHIP are financed by a general fund appropriation provided by Congress. Employment tax revenue is Medicare's portion of payroll and self-employment taxes collected under the Federal Insurance Contribution Act (FICA) and Self-Employment Contribution Act (SECA) for the HI Trust Fund totaling $150.3 billion. The Federal matching contribution is income to the SMI program from a general fund appropriation (Payments to Health Care Trust Funds) of $71.4 billion, that matches monthly premiums paid by beneficiaries.

## Combined Statement of Budgetary Resources

The Combined Statement of Budgetary Resources provides information about the availability of budgetary resources, as well as their status at the end of the year. CMS's total budgetary resources were $461.2 billion. Obligations of $460.8 billion leave available unobligated balances of $186 million. Total outlays were $450.2 billion. Net outlays were $351.1 billion. The difference is comprised of $75.4 billion in the Payments to Health Care Trust Funds, which is appropriated from the general fund into the SMI Trust Fund, then expended as benefit payments; and $23.7 billion relating to collection of premiums.

## Consolidated Statement of Financing

The Consolidated Statement of Financing is a reconciliation of the preceding statements. Accrual-based measures used in the Consolidated Statement of Net Cost differ from the obligation-based measures used in the Combined Statement of Budgetary Resources,

especially in the treatment of liabilities. A liability not covered by budgetary resources may not be recorded as a funded liability in the budgetary accounts of CMS's general ledger, which supports the Report on Budget Execution (SF-133) and the Combined Statement of Budgetary Resources. Therefore, these liabilities are recorded as contingent liabilities on the general ledger. Based on appropriation language, they are considered "funded" liabilities for purposes of the Consolidating Balance Sheet, Consolidating Statement of Net Cost and Consolidating Statement of Changes in Net Position. A reconciling item has been entered on the Consolidated Statement of Financing.

## Required Supplementary Stewardship Information

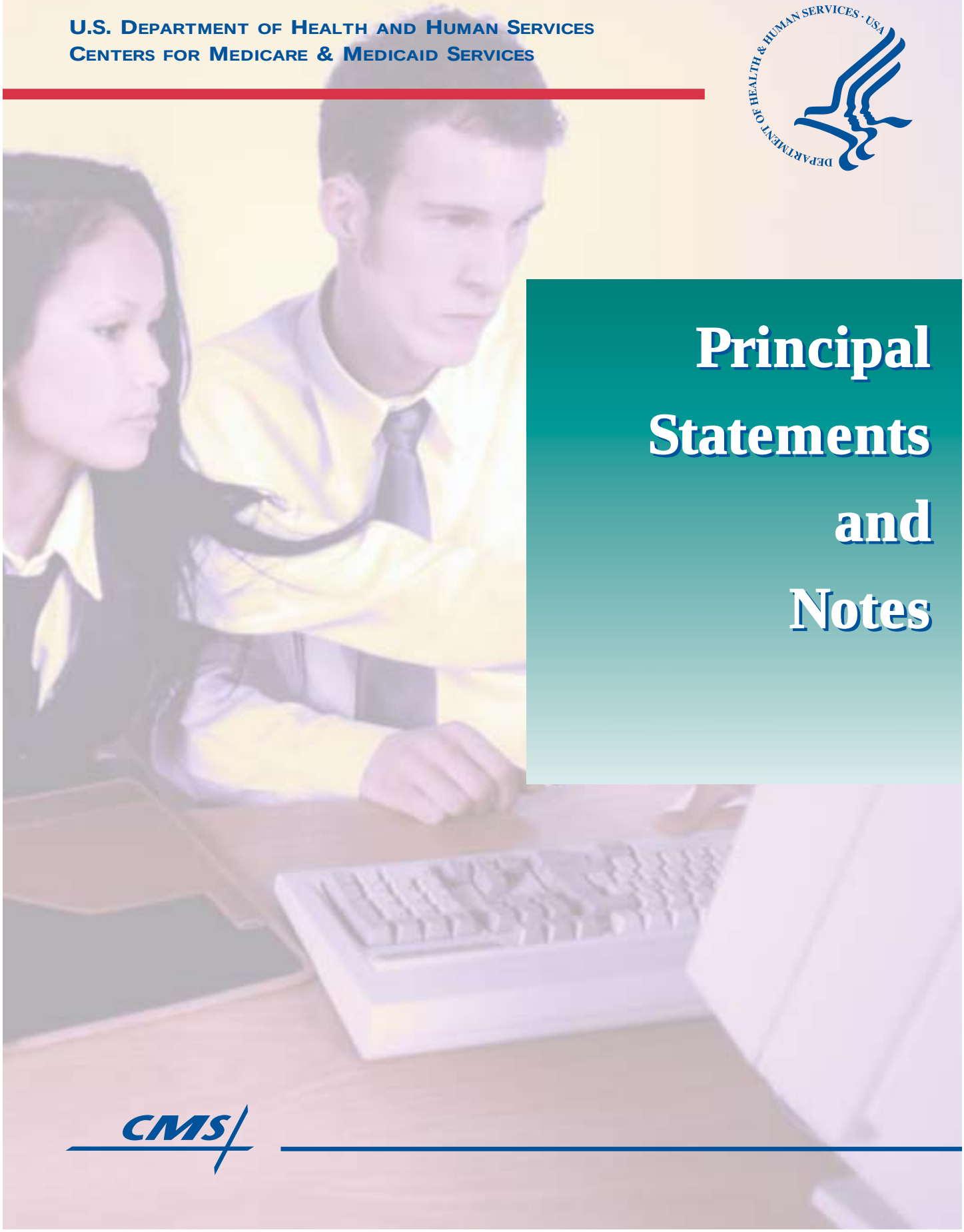
As required by the Statement of Federal Financial Accounting Standards (SFFAS) Number 10, CMS has included information about the Medicare Trust Funds—HI and SMI. The Required Supplementary Stewardship Information (RSSI) assists users in evaluating operations and aids in assessing the sufficiency of future budgetary resources to sustain program services and meet program obligations as they come due. The information is drawn from the ***2001 Annual Report of the Board of Trustees of the Federal HI Trust Fund*** and the ***2001 Annual Report of the Board of Trustees of the Federal SMI Trust Fund***, which represent the official government evaluation of the financial and actuarial status of the Medicare Trust Funds.

## Limitations of the Financial Statements

The financial statements have been prepared to report the financial position and results of operations of CMS, pursuant to the requirements of 31 U.S.C. 3515(b) and the Chief Financial Officers Act of 1990 (P.L. 101-576).

While these financial statements have been prepared from CMS's general ledger and subsidiary reports and supplemented with financial data provided by the U.S. Treasury in accordance with the formats prescribed by OMB, the statements are in addition to the financial reports used to monitor and control budgetary resources which are prepared from the same books and records. These statements use accrual accounting, and some amounts shown will differ from those in other financial documents, such as the ***Budget of the U.S. Government*** and the annual reports of the Boards of Trustees for HI and SMI, which are presented on a cash basis. The statements should be read with the realization that they are for a component of the United States government, a sovereign entity. One implication of this is that liabilities cannot be liquidated without legislation that provides resources to do so. The accuracy and propriety of the information contained in the principal financial statements and the quality of internal control rests with management.

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services



# Principal Statements and Notes

CMS

# CONSOLIDATING BALANCE SHEET
## As of September 30, 2001
(in millions)

| | Combined Totals | Intra-CMS Eliminations | FY 2001 Consolidated Totals | FY 2000 Consolidated Totals Restated |
|---|---|---|---|---|
| **ASSETS** | | | | |
| **Intragovernmental Assets:** | | | | |
| Fund Balance with Treasury ***(Note 2)*** | $17,427 | | $17,427 | $20,091 |
| Trust Fund Investments ***(Note 3)*** | 243,092 | | 243,092 | 217,566 |
| Accounts Receivable, Net | 4,802 | $(4,248) | 554 | 484 |
| Employment Tax Adjustment ***(Note 4)*** | | | | 1,313 |
| Other Assets ***(Note 5)*** | | | | |
| Anticipated Congressional Appropriation | 11,166 | | 11,166 | 6,561 |
| **Total Intragovernmental Assets** | **$276,487** | **$(4,248)** | **$272,239** | **$246,015** |
| Accounts Receivable, Net ***(Note 6)*** | $4,086 | | $4,086 | $3,878 |
| Advances to Grantees | | | | 2 |
| Cash and Other Monetary Assets | 137 | | 137 | 61 |
| Property, Plant and Equipment, Net | 12 | | 12 | 18 |
| **TOTAL ASSETS** | **$280,722** | **$(4,248)** | **$276,474** | **$249,974** |
| **LIABILITIES** ***(Note 9)*** | | | | |
| **Intragovernmental Liabilities:** | | | | |
| Accounts Payable | $26 | $(26) | | |
| Accrued Payroll and Benefits | 4 | | $4 | $4 |
| Other Intragovernmental Liabilities ***(Note 7)*** | 4,920 | (4,222) | 698 | 427 |
| **Total Intragovernmental Liabilities** | **$4,950** | **$(4,248)** | **$702** | **$431** |
| Accounts Payable | | | | $33 |
| Entitlement Benefits Due and Payable ***(Note 8)*** | $40,441 | | $40,441 | 36,516 |
| Federal Employee and Veterans' Benefits | 10 | | 10 | 10 |
| Accrued Payroll and Benefits | 55 | | 55 | 66 |
| Other Liabilities ***(Note 7)*** | 210 | | 210 | 187 |
| **TOTAL LIABILITIES** | **$45,666** | **$(4,248)** | **$41,418** | **$37,243** |
| **NET POSITION** | | | | |
| Unexpended Appropriations ***(Note 10)*** | $11,564 | | $11,564 | $14,119 |
| Cumulative Results of Operations | 223,492 | | 223,492 | 198,612 |
| **TOTAL NET POSITION** | **$235,056** | | **$235,056** | **$212,731** |
| **TOTAL LIABILITIES and NET POSITION** | **$280,722** | **$(4,248)** | **$276,474** | **$249,974** |

*The accompanying notes are an integral part of these statements.*

## CONSOLIDATING STATEMENT OF NET COST
## Year Ended September 30, 2001
(in millions)

| | Combined Totals | Intra-CMS Eliminations | FY 2001 Consolidated Totals | FY 2000 Consolidated Totals |
|---|---|---|---|---|
| **NET PROGRAM/ACTIVITY COSTS** | | | | |
| **GPRA Programs** | | | | |
| Medicare *(Includes estimated improper payments of $7.2-$16.9 billion)* ***(Note 11)*** | $219,357 | | $219,357 | $197,041 |
| Medicaid | 129,211 | $1,239 | 130,450 | 118,705 |
| SCHIP | 3,726 | (1,239) | 2,487 | 1,273 |
| **Net Cost - GPRA Programs** | **$352,294** | | **$352,294** | **$317,019** |
| **Other Activities** | | | | |
| CLIA | $83 | | $83 | $(18) |
| Ticket to Work Incentive | 2 | | 2 | |
| Other | 2 | | 2 | 5 |
| **Net Cost - Other Activities** | **$87** | | **$87** | **$(13)** |
| **NET COST OF OPERATIONS** ***(Note 12)*** | **$352,381** | | **$352,381** | **$317,006** |

*The accompanying notes are an integral part of these statements.*

## CONSOLIDATING STATEMENT OF CHANGES IN NET POSITION
## Year Ended September 30, 2001
(in millions)

| | Combined Totals | Intra-CMS Eliminations | Consolidated Totals |
|---|---|---|---|
| **NET COST OF OPERATIONS** | **$352,381** | | **$352,381** |
| **Financing Sources** (other than exchange revenues): | | | |
| Appropriations Used | $212,325 | | $212,325 |
| Taxes and Other Non-exchange Revenue ***(Note 13)*** | 166,658 | | 166,658 |
| Imputed Financing | 27 | | 27 |
| Transfers-In | | | |
| Non-Expenditure Transfers-Benefit Payments | 237,740 | $(237,740) | |
| Trust Fund Draws | 2,265 | (2,265) | |
| Federal Matching Contributions ***(Note 14)*** | 71,430 | (71,430) | |
| Other ***(Note 15)*** | 8,780 | (8,283) | 497 |
| Transfers-Out | | | |
| Non-Expenditure Transfers-Benefit Payments | (237,740) | 237,740 | |
| Expenditure Transfers to Program Management | (2,265) | 2,265 | |
| Payments to Health Care Trust Funds | (79,653) | 79,653 | |
| Other ***(Note 15)*** | (2,299) | 60 | (2,239) |
| Other Revenues and Financing Sources | | | |
| Reclassification of Equity Accounts | (7) | | (7) |
| **TOTAL FINANCING SOURCES** | **$377,261** | | **$377,261** |
| **Net Results of Operations** | **24,880** | | **24,880** |
| **Net Change in Cumulative Results of Operations** | **24,880** | | **24,880** |
| **(**Decrease) in Unexpended Appropriations ***(Note 16)*** | (2,555) | | (2,555) |
| **Change in Net Position** | **22,325** | | **22,325** |
| Net Position–Beginning of Period | 212,731 | | 212,731 |
| **Net Position–End of Period** | **$235,056** | | **$235,056** |

*The accompanying notes are an integral part of these statements.*

## COMBINED STATEMENT OF BUDGETARY RESOURCES
## Year Ended September 30, 2001

(in millions)

| | Combined Totals |
|---|---|
| **Budgetary Resources:** | |
| Budget authority | $477,629 |
| Unobligated balances - beginning of period | 3,491 |
| Net transfers prior year balance, actual | |
| Spending authority from offsetting collections | 3,566 |
| Adjustments | (23,512) |
| **TOTAL BUDGETARY RESOURCES** | **$461,174** |
| **Status of Budgetary Resources:** | |
| Obligations incurred | $460,776 |
| Unobligated balances–available | 186 |
| Unobligated balances–not available | 212 |
| **TOTAL STATUS OF BUDGETARY RESOURCES** | **$461,174** |
| **Outlays:** | |
| Obligations incurred | $460,776 |
| Less: spending authority from offsetting collections and adjustments | (10,397) |
| Obligated balance, net–beginning of period | 17,559 |
| Obligated balance transferred, net | |
| Less: obligated balance, net–end of period | (17,766) |
| **TOTAL OUTLAYS** | **$450,172** |

*The accompanying notes are an integral part of these statements.*

## CONSOLIDATED STATEMENT OF FINANCING
## Year Ended September 30, 2001
(in millions)

| | Consolidated Totals |
|---|---|
| **RESOURCES USED TO FINANCE ACTIVITIES** | |
| **Budgetary** | |
| Budgetary resources obligated for orders, delivery of goods and services to be received, or benefits to be provided to others | $460,776 |
| Less: offsetting collections, and recoveries of prior-year authority | (10,460) |
| Obligations net of offsetting collections and recoveries | 450,316 |
| Less: Trust Fund Premiums collected | (23,746) |
| **Net Budgetary Resources Used to Finance Activities** | **$426,570** |
| **Non-budgetary** | |
| Imputed financing from costs incurred by others | 27 |
| **Net Non-budgetary Resources Used to Finance Activities** | **$27** |
| **TOTAL RESOURCES USED TO FINANCE ACTIVITIES** | **$426,597** |
| **RESOURCES USED TO FINANCE ITEMS NOT PART OF THE NET COST of OPERATIONS:** | |
| Budgetary resources that fund expenses recognized in prior periods | $36,516 |
| Increase in budgetary resources obligated to order goods and services not yet received or benefits not yet provided | 7,646 |
| Adjustments other than collections made to compute net budgetary resources that do not affect net cost of operations: | |
| Recoveries of prior-year authority | (7,233) |
| Resources that do not affect net cost of operations | 81,894 |
| Resources that finance the acquisition of assets or liquidation of liabilities | 2 |
| **TOTAL RESOURCES USED TO FINANCE ITEMS NOT PART OF THE NET COST OF OPERATIONS** | **$118,825** |
| **TOTAL RESOURCES USED TO FINANCE THE NET COST OF OPERATIONS** | **$307,772** |
| **COMPONENTS OF NET COST OF OPERATIONS THAT WILL NOT REQUIRE OR GENERATE RESOURCES IN THE CURRENT PERIOD:** | |
| Expenses or exchange revenue related to the disposition of assets or liabilities, or allocation of their costs over time: | |
| Expenses related to use of assets | $181 |
| Losses from revaluation of assets | 1 |
| (Increase) in exchange revenue receivable from the public | (383) |
| (Increase) in cash and other monetary assets | (76) |
| Expenses that will be financed with budgetary resources recognized in future periods: | |
| Accrued Entitlement Benefit Costs | 40,441 |
| Add: decrease in budgetary resources currently available | 222 |
| Accrued Entitlement Benefit Costs, Net | 40,663 |
| Increase in Accrued Payroll and Benefits liability | 1 |
| Other | 4,222 |
| **TOTAL COMPONENTS OF NET COST OF OPERATIONS THAT WILL NOT REQUIRE OR GENERATE RESOURCES IN THE CURRENT PERIOD** | **$44,609** |
| **NET COST OF OPERATIONS** | **$352,381** |

*The accompanying notes are an integral part of these statements.*

# NOTE 1: SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

## Reporting Entity

The Centers for Medicare & Medicaid Services (CMS) is a separate financial reporting entity of the Department of Health and Human Services (HHS). The financial statements have been prepared to report the financial position and results of operations of CMS, as required by the Chief Financial Officers Act of 1990. The statements were prepared from CMS's accounting records in accordance with accounting principles generally accepted in the United States (GAAP) and the form and content specified by the Office of Management and Budget (OMB) in OMB Bulletin 97-01 (as amended) as well as with certain provisions which became effective in FY 2001 under OMB Bulletin 01-09.

The financial statements cover all the programs administered by CMS. The programs administered by CMS are shown in two categories, Medicare and Health. The Medicare programs include:

### *Medicare Hospital Insurance (HI) Trust Fund*

Medicare contractors are paid by CMS to process Medicare claims for hospital inpatient services, hospice, and certain skilled nursing and home health services. Benefit payments made by the Medicare contractors for these services, as well as administrative costs, are charged to the HI Trust Fund. CMS payments to managed care plans are also charged to this fund. The financial statements include HI Trust Fund activities administered by the Department of the Treasury (Treasury).

### *Medicare Supplementary Medical Insurance (SMI) Trust Fund*

Medicare contractors are paid by CMS to process Medicare claims for physicians, medical suppliers, hospital outpatient services and rehabilitation, end stage renal disease (ESRD), rural health clinics, and certain skilled nursing and home health services. Benefit payments made by the Medicare contractors for these services, as well as administrative costs, are charged to the SMI Trust Fund. CMS payments to managed care plans are also charged to this fund. The financial statements include SMI Trust Fund activities administered by Treasury.

### *Medicare Integrity Program (MIP)*

The Health Insurance Portability and Accountability Act, Public Law 104-191, established the MIP, codifying the program integrity activities previously known as "payment safeguards." This account is also called the Health Care Fraud and Abuse Control (HCFAC) Program, or simply "Fraud and Abuse." The MIP contracts with eligible entities to perform such activities as medical and utilization reviews, fraud

reviews, cost report audits, and the education of providers and beneficiaries with respect to payment integrity and benefit quality assurance issues. The MIP is funded by the HI Trust Fund.

## Payments to the Health Care Trust Funds Appropriation

The Social Security Act provides for payments to the HI and SMI Trust Funds for SMI (appropriated funds to provide for Federal matching of SMI premium collections) and HI (for the Uninsured and Federal Uninsured Payments). In addition, funds are provided by this appropriation to cover the Medicaid program's share of CMS's administrative costs. To prevent duplicative reporting, the Fund Balance, Unexpended Appropriation, Financing Sources and Expenditure Transfers of this appropriation are reported only in the Medicare HI and SMI columns of the financial statements.

## Permanent Appropriations

A transfer of general funds to the HI Trust Fund in amounts equal to Self-Employment Contribution Act (SECA) tax credits and the increase to the tax payment from Old Age Survivors and Disability Insurance (OASDI) beneficiaries is made through 75X0513 and 75X0585, respectively. The Social Security Amendments of 1983 provided credits against the HI taxes imposed by the SECA on the self-employed for calendar years 1984 through 1989. The amounts reported in FY 2001 are adjustments for late or amended tax returns. The Social Security Amendments of 1994, provided for additional tax payments from Social Security and Tier 1 Railroad Retirement beneficiaries.

The Health programs include:

## Medicaid

Medicaid, the health care program for low-income Americans, is administered by CMS in partnership with the States. Grant awards limit the funds that can be drawn by the States to cover current expenses. The grant awards, prepared at the beginning of each quarter and amended as necessary, are an estimate of CMS's share of States' Medicaid costs. At the end of each quarter, States report their expenses (net of recoveries) for the quarter, and subsequent grant awards are issued by CMS for the difference between approved expenses reported for the period and the grant awards previously issued.

## The State Children's Health Insurance Program (SCHIP)

SCHIP, included in the Balanced Budget Act of 1997 (BBA), was designed to provide health insurance for children, many of whom come from working families with incomes too high to qualify for Medicaid, but too low to afford private health insurance. The BBA set aside funds for ten years to provide this new insurance coverage. The grant awards, prepared at the beginning of each quarter and amended as necessary, are based on a State approved plan to implement SCHIP. At the end of each quarter, States report their expenses (net of recoveries) for the quarter, and subsequent grant awards are issued by CMS for the difference between approved expenses reported for the period and the grant awards previously issued.

## The Ticket to Work and Work Incentives Improvement Program

The Ticket to Work and Work Incentives Improvement Act of 1999, Public Law 106-170, established two grant programs. The Act program provides funding for Medicaid infrastructure grants to support the design, establishment and operation of State infrastructures to help working people with disabililites purchase health coverage through Medicaid. The Act also provides funding for States to establish Demonstrations to Maintain Independence and Employment, which will provide Medicaid benefits and services to working individuals who have a condition that, without medical assistance, will result in disability.

## Health Maintenance Organization (HMO) Loan and Loan Guarantee Fund

The HMO Loan and Loan Guarantee Fund was originally established to provide working capital to HMOs during their initial period of operations and to guarantee loans made by private lenders to HMOs. The last loan commitments were made in FY 1983. Direct loans to HMOs were sold, with a guarantee, to the Federal Financing Bank (FFB). The FFB purchase proceeds were then used as capital for additional direct loans. Therefore, the fund operates as a revolving fund. Currently, CMS collects principal and interest payments from HMO borrowers, and, in turn, pays the FFB.

## Program Management User Fees: Medicare+Choice, Clinical Laboratory Improvement Program, and Other User Fees

This account operates as a revolving fund without fiscal year restriction. The BBA established the Medicare+Choice program that requires managed care plans to make payments for their share of the estimated costs related to enrollment, dissemination of information, and certain counseling and assistance programs. These user fees are devoted to educational efforts for beneficiaries and outreach partners. The Clinical Laboratory Improvement Amendments of 1988 (CLIA) marked the first comprehensive effort by the Federal government to regulate medical laboratory testing. CMS and the Public Health Service share responsibility for the CLIA program, with CMS having the lead responsibility for financial management. Fees for registration, certificates, and compliance determination of all U.S. clinical laboratories are collected to finance the program. Other user fees are charged for certification of some nursing facilities and for sale of the data on nursing facilities surveys. Proceeds from the sale of data from the public use files and publications under the Freedom of Information Act (FOIA) are also credited to this fund.

## Program Management Appropriation

The Program Management Appropriation provides CMS with the major source of administrative funds to manage the Medicare and Medicaid programs. The funds for this activity are provided from the HI and SMI Trust Funds, the general fund, and reimbursable activities. The Payments to the Health Care Trust Funds Appropriation reimburses the Medicare HI Trust Fund to cover the Medicaid program's share of CMS's administrative costs (see Note 12). User fees collected from managed care plans seeking

Federal qualification and funds received from other Federal agencies to reimburse CMS for services performed for them are credited to the Program Management Appropriation.

The cost related to the Program Management Appropriation is allocated among all programs based on CMS's cost allocation system. It is reported in the Medicare and Health columns of the Consolidating Statement of Net Cost in the Supplementary Financial Statement Section.

## Basis of Presentation

The financial statements have been prepared to report the financial position and results of operations of CMS, pursuant to the requirements of 31 U.S.C. 3515(b), the Chief Financial Officers Act of 1990 (P.L. 101-576), and amended by the Government Management Reform Act of 1994.

These financial statements have been prepared from CMS's general ledger in accordance with GAAP and the formats prescribed by the OMB Bulletin 97-01 (as amended) as well as with certain provisions of OMB Bulletin 01-09. Some amounts shown will differ from those in other financial documents, such as the ***Budget of the U.S. Government*** and the annual reports of the Boards of Trustees for HI and SMI, which are presented on a cash basis.

## Basis of Accounting

CMS uses the Government's Standard General Ledger account structure and follows accounting policies and guidelines issued by HHS. The financial statements are prepared on an accrual basis. Individual accounting transactions are recorded using both the accrual basis and cash basis of accounting. Under the accrual method, expenses are recognized when resources are consumed, without regard to the payment of cash. Under the cash method, expenses are recognized when cash is outlayed. CMS follows standard budgetary accounting principles that facilitate compliance with legal constraints and controls over the use of Federal funds.

CMS uses the cash basis of accounting in the Medicare program to record benefit payments disbursed during the fiscal year, supplemented by the accrual method to estimate the value of benefit payments incurred but not yet paid as of the fiscal year end. Revenues are also recognized both when earned (without regard to receipt of cash) and, in the case of HI and SMI premiums, when collected. Employment taxes earmarked for the Medicare program are recorded on a cash basis.

CMS uses the cash basis of accounting in the Medicaid and SCHIP programs to record funds paid to the States during the fiscal year, supplemented by the accrual method to estimate the value of expenses (net of recoveries) not yet reported to CMS as of the end of the fiscal year.

## Consolidating Balance Sheet

The Consolidating Balance Sheet presents amounts of future economic benefits owned or managed by CMS (assets), amounts owed (liabilities), and amounts which comprise the difference (net position). The major components are described below.

**Assets**

**Fund Balances** are funds with Treasury that are primarily available to pay current liabilities. Cash receipts and disbursements are processed by Treasury. CMS also maintains lockboxes at commercial banks for the deposit of SMI premiums from States and third parties and for collections from HMO plans.

**Trust Fund Investments** are investments (plus the accrued interest on investments) held by Treasury. Sections 1817 for HI and 1841 for SMI of the Social Security Act require that trust fund investments not necessary to meet current expenditures be invested in "interest-bearing obligations of the United States or in obligations guaranteed as to both principal and interest by the United States." These investments are carried at face value as determined by Treasury. Interest income is compounded semiannually (June and December) and has been adjusted to include an accrual for interest earned from July 1 to September 30.

**Accounts Receivable, Net** consists of amounts owed to CMS by other Federal agencies and the public. Amounts due are presented net of an allowance for uncollectible accounts.

> ***Medicare Secondary Payer (MSP) Accounts Receivable (A/R)*** consists of amounts owed to Medicare by insurance companies, employers, beneficiaries, and/or providers for payments made by Medicare that should have been paid by the primary payer. Receipts are transferred to the HI or SMI Trust Fund upon collection. Amounts due are presented net of an allowance for uncollectible accounts. The allowance for uncollectible accounts is based on past collection experience and an analysis of the outstanding balances.
>
> ***Medicare Non-MSP A/R*** consists of amounts owed to Medicare by medical providers and others because Medicare made payments that were not due, for example, excess payments that were determined to have been made once provider cost reports were audited. Non-MSP A/R represent entity receivables and, once collected, are transferred to the HI or SMI Trust Fund. Amounts due are presented net of an allowance for uncollectible accounts. The allowance for uncollectible accounts is based on past collection experience and an analysis of the outstanding balances.

**Advances to Grantees** are used to report advance payments made to health care providers. These occur when there are billing or claims processing problems and health providers ask for accelerated Medicare payments to minimize problems related to cash flow.

**Cash and Other Monetary Assets** are the total amount of time account balances at the Medicare contractors' commercial banks. The Checks Paid Letter-of-Credit method is used for reimbursing Medicare contractors for the payment of covered Medicare services. Medicare contractors issue checks against a Medicare Benefits account maintained at commercial banks. In order to compensate commercial banks for handling the Medicare Benefits accounts, Medicare funds are deposited into non-interest-bearing time accounts. The earnings allowances on the time accounts are used to reimburse the commercial banks.

**Property, Plant and Equipment (PP&E)** are recorded at full cost of purchase, including all costs incurred to bring the PP&E to a form and location suitable for its intended use, net of accumulated depreciation. All PP&E with an initial acquisition cost of $25,000 or more and an estimated useful life of 2 years or greater is capitalized. PP&E is depreciated on a straight-line basis over the estimated useful life of the asset. Normal maintenance and repair costs are expensed as incurred.

**Liabilities** represent amounts owed by CMS as the result of transactions that have occurred. In accordance with Public Law and existing Federal accounting standards, no liability is recorded for any future payment to be made on behalf of current workers contributing to the Medicare HI Trust Fund.

Liabilities covered by available budgetary resources include (1) new budget authority, (2) spending authority from offsetting collections, (3) recoveries of unexpired budget authority, (4) unobligated balances of budgetary resources at the beginning of the year, and (5) permanent indefinite appropriation or borrowing authority.

Liabilities not covered by budgetary resources are incurred when funding has not yet been made available through Congressional appropriations or current earnings. CMS recognizes such liabilities for employee annual leave earned but not taken, and amounts billed by the Department of Labor for Federal Employee's Compensation Act (FECA) payments. For CMS revolving funds, all liabilities are funded as they occur.

**Accounts Payable** consists of amounts due for goods and services received, progress in contract performance, interest due on accounts payable, and other miscellaneous payables.

**Entitlement Benefits Due and Payable** represent Medicare or Medicaid medical services incurred but not paid as of September 30. The Medicare estimate is developed by the Office of the Actuary (OACT) and is based on historical trends of completeness that take into consideration estimated deductible and coinsurance amounts. The estimate represents (1) claims incurred that may or may not have been submitted to the Medicare contractors and were not yet approved for payment, (2) claims that have been approved for payment by the Medicare contractors for which checks have not yet been issued, (3) checks that have been issued by the Medicare contractors in payment of a claim and that have not yet been cashed by payees, (4) periodic interim payments, and (5) retroactive settlements of cost reports.

The Medicaid amount reported is the net of unreported expenses incurred by the States less amounts owed to the States for overpayment of Medicaid funds to providers, anticipated rebates from drug manufacturers, and settlements of probate and fraud and abuse cases. This information was provided by the States.

**Federal Employee and Veterans' Benefits** consist of the actuarial portions of future benefits earned by Federal employees and Veterans, but not yet due and payable. These costs include pensions, other retirement benefits, and other post-employment benefits. These benefits programs are normally administered by the Office of Personnel Management (OPM) and not by CMS.

**Accrued Payroll and Benefits** consist of Workers Compensation (FECA) payments due to the Department of Labor and the estimated liability for salaries, wages, funded annual leave and sick leave that has been earned but is unpaid.

**Other Liabilities** are the retirement plans utilized by CMS employees; the Civil Service Retirement System (CSRS) or the Federal Employees Retirement System (FERS). Under CSRS, CMS makes matching contributions equal to 7 percent of pay. CMS does not report CSRS assets, accumulated plan benefits, or unfunded liabilities, if any, applicable to its employees. Reporting such amounts is the responsibility of the Office of Personnel Management.

Most employees hired after December 31, 1983 are automatically covered by FERS. A primary feature of FERS is that it offers a savings plan to which CMS is required to contribute 1 percent of pay and to match employee contributions up to an additional 4 percent of pay. For employees covered by FERS, CMS also contributes the employer's matching share of Social Security taxes.

**Net Position** contains the following components:

***Unexpended Appropriations*** include the portion of CMS's appropriations represented by undelivered orders and unobligated balances.

***Cumulative Results of Operations*** represent the net results of operations since the inception of the program plus the cumulative amount of prior period adjustments.

## Consolidating Statement of Net Cost

In FY 2001 the Consolidated Statement of Net Cost shows only a single amount: the actual net cost of CMS's operations for the period by program. Under GPRA, CMS is required to identify the mission of the agency and develop a strategic plan and performance measures to show that desired outcomes are being met. The three major programs that CMS administers are: Medicare, Medicaid, and SCHIP. The bulk of CMS's expenses are allocated to these programs. MIP is included in Medicare. The costs related to the Program Management Appropriation are cost allocated to all three major components. The net cost of operations of the CLIA program and other programs are shown separately under "Other Activities."

Although the following terms do not appear in the Consolidated Statement of Net Cost, they are an integral part in the calculation of a program's net cost of operations:

**Program/Activity Costs** represent the gross costs or expenses incurred by CMS for all activities.

***Benefit Payments*** are the payments by Medicare contractors, CMS, and Medicaid State agencies to health care providers for their services.

***Administrative Expenses*** represent the costs of doing business by CMS and its partners.

**Earned Revenues** or exchange revenues arise when a Government entity provides goods and services to the public or to another Government entity for a fee.

***Premiums Collected*** are used to finance SMI benefits and administrative expenses. Monthly premiums paid by Medicare beneficiaries are matched by the Federal government through the general fund appropriation, Payments to the Health Care Trust Funds. Section 1844 of the Social Security Act authorizes appropriated funds to match SMI premiums collected, and outlines the ratio for the match as well as the method to make the trust funds whole if insufficient funds are available in the appropriation to match all premiums received in the fiscal year.

**Net Cost of Operations** is the difference between the program's gross costs and its related exchange revenues.

## Consolidating Statement of Changes in Net Position

The Consolidating Statement of Changes in Net Position shows the net results of operations (financing sources other than exchange revenues, less net cost of operations) and the net position at the end of period. Major components are described below.

**Financing Sources (Other than Exchange Revenues)** arise primarily from exercise of the Government's power to demand payments from the public (e.g., taxes, duties, fines, and penalties). These include appropriations used, transfers of assets from other Government entities, donations, and imputed financing.

**Appropriations Used and Federal Matching Contributions** are described in the Medicare Premiums section above. For financial statement purposes, appropriations used are recognized as a financing source as expenses are incurred. A transfer of general funds to the HI Trust Fund in an amount equal to Self-Employment Contribution Act (SECA) tax credits is made through the Payments to the Health Care Trust Funds Appropriation. The Social Security Amendments of 1983 provided credits against the HI taxes imposed by the SECA on the self-employed for calendar years 1984 through 1989.

**Employment Tax Revenue** is the primary source of financing for Medicare's HI program. Medicare's portion of payroll and self-employment taxes is collected under the Federal Insurance Contribution Act (FICA) and Self-Employment Contribution Act (SECA). Employees and employers were both required to contribute 1.45 percent of earnings, with no limitation, to the HI Trust Fund. Self-employed individuals contributed the full 2.9 percent of their net income.

**Transfers-In/Transfers-Out** report the transfers of funds between CMS programs or between CMS and other Federal agencies. Examples include transfers made from CMS's Payment to the Health Care Trust Fund appropriation to the HI and SMI Trust Funds and the transfers between the HI and SMI Trust Funds and CMS's Program Management appropriation.

## Combined Statement of Budgetary Resources

The Combined Statement of Budgetary Resources provides information about the availability of budgetary resources as well as their status at the end of the year. Budgetary Statements were developed for each of the budgetary accounts. In this

statement, the Program Management and the Program Management User Fee accounts are combined and are not allocated back to the other programs. Also, there are no intra-CMS eliminations in this statement. CMS was required to return the unobligated balance of the indefinite authority appropriated to Medicaid in the last quarter of FY 2001 to the general fund of Treasury.

**Unobligated Balances—beginning of period** represent funds available. These funds are primarily HI and SMI Trust Fund balances invested by the Treasury.

**Budget Authority** represents the funds available through appropriations, direct spending authority, obligations limitations, unobligated balances at the beginning of the period or transferred in during the period, spending authority from offsetting collections, and any adjustments to budgetary authority.

**Obligations Incurred** consists of expended authority, recoveries of prior year obligations and the change in undelivered orders.

**Adjustments** are increases or (decreases) to budgetary resources. Increases include recoveries of prior year obligations; decreases include budgetary resources temporarily not available, recissions, and cancellations of expired and no-year accounts.

## *Consolidated Statement of Financing*

The Consolidated Statement of Financing is a reconciliation of the preceding statements. Accrual-based measures used in the Consolidating Statement of Net Cost differ from the obligation-based measures used in the Combined Statement of Budgetary Resources, especially in the treatment of liabilities. A liability not covered by budgetary resources may not be recorded as a funded liability in the budgetary accounts of CMS's general ledger, which supports the Report on Budget Execution (SF-133) and the Combined Statement of Budgetary Resources. Therefore, these liabilities are recorded as contingent liabilities on the general ledger. Based on appropriation language, they are considered "funded" liabilities for purposes of the Consolidating Balance Sheet, Consolidating Statement of Net Cost and Consolidating Statement of Changes in Net Position. A reconciling item has been entered on the Consolidated Statement of Financing, which has been prepared on a consolidated basis, except for the budgetary information used to calculate net obligations (budgetary resources), which must be presented on a combined basis.

## *Use of Estimates in Preparing Financial Statements*

Preparation of financial statements in accordance with Federal accounting standards requires CMS to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenues and expenses during the reporting period. Actual results may differ from those estimates.

## *Intra-Governmental Relationships and Transactions*

In the course of its operations, CMS has relationships and financial transactions with numerous Federal agencies. For example, CMS interacts with the Social Security

Administration (SSA) and Treasury. SSA determines eligibility for Medicare programs, and also allocates a portion of Social Security benefit payments to the Medicare Part B Trust Fund for Social Security beneficiaries who elect to enroll in the Medicare Part B program. The Treasury receives the cumulative excess of Medicare receipts and other financing sources, and issues interest-bearing securities in exchange for the use of those monies. At the Government-wide level, the assets related to the trust funds on CMS's financial statements and the corresponding liabilities on the Treasury's financial statements are eliminated.

## Comparative Data

In accordance with OMB Bulletin 01-09, CMS has presented a comparative Balance Sheet and Statement of Net Cost for FY 2000.

## Estimation of Obligations Related to Canceled Appropriations

As of September 30, 2001, CMS has canceled over $128 million in cumulative obligations to FY 1995 and prior years in accordance with the National Defense Authorization Act of Fiscal Year 1991 (P.L. 101-150). Based on the payments made in FY 1997 through 2001 related to canceled appropriations, CMS anticipates an additional $1.5 million will be paid from current year funds for canceled obligations.

# NOTE 2: FUND BALANCE WITH TREASURY *(Dollars in Millions)*

| FY 2001 | Entity Assets Unrestricted | Entity Assets Restricted | Consolidated Total |
|---|---|---|---|
| **Trust Funds** | | | |
| HI Trust Fund Balance *(1)* | $290 | $3 | $293 |
| SMI Trust Fund Balance *(1)* | (69) | | (69) |
| **Revolving Funds** | | | |
| HMO Loan *(2)* | 10 | | 10 |
| CLIA *(2)* | 141 | | 141 |
| **Appropriated Funds** | | | |
| Medicaid | 5,462 | | 5,462 |
| SCHIP | 11,501 | | 11,501 |
| TWI *(2)* | 60 | | 60 |
| **Other Fund Types** | | | |
| CMS Suspense Account *(2)* | 16 | | 16 |
| Program Management Reimbursables *(2)* | 13 | | 13 |
| **TOTAL FUND BALANCES** | **$17,424** | **$3** | **$17,427** |

***(1)*** The restricted portion of the HI fund balance represents the remaining fund balance in the Payments to the Health Care Trust Funds appropriation, which is allocated to HI. There was no remaining fund balance in the SMI allocation of the Payments to the Health Care Trust Funds appropriation.

***(2)*** These fund balances are reported in the Supplementary Financial Statement section under the "All Others" column of the Consolidating Balance Sheet.

| FY 2000 | Entity Assets Unrestricted | Entity Assets Restricted | Consolidated Total |
|---|---|---|---|
| **Trust Funds** | | | |
| HI Trust Fund Balance *(1)* | $(775) | $13 | $(762) |
| SMI Trust Fund Balance *(1)* | 847 | 3,129 | 3,976 |
| **Revolving Funds** | | | |
| HMO Loan *(2)* | 10 | | 10 |
| CLIA *(2)* | 194 | | 194 |
| **Appropriated Funds** | | | |
| Medicaid | 5,694 | | 5,694 |
| SCHIP | 10,951 | | 10,951 |
| **Other Fund Types** | | | |
| CMS Suspense Account *(2)* | 14 | | 14 |
| Program Management Reimbursables *(2)* | 14 | | 14 |
| **TOTAL FUND BALANCES** | **$16,949** | **$3,142** | **$20,091** |

***(1)*** The restricted portion of the HI and SMI fund balances represents the remaining fund balance in the Payments to the Health Care Trust Funds appropriation, which is allocated to HI and SMI.

***(2)*** These fund balances are reported in the Supplementary Financial Statement section under the "All Others" column of the Consolidating Balance Sheet.

# NOTE 3: TRUST FUND INVESTMENTS, NET *(Dollars in Millions)*

## Medicare Investments

| FY 2001 | Maturity Range | Interest Range | Value |
|---|---|---|---|
| **HI** | | | |
| Certificates | June 2002 | 5 1/8 - 5 5/8% | $2,381 |
| Bonds | June 2002 to June 2016 | 5 5/8 - 9 1/4% | 194,756 |
| Accrued Interest | | | 3,272 |
| **TOTAL HI INVESTMENTS** | | | **$200,409** |
| **SMI** | | | |
| Bonds | June 2002 to June 2016 | 5 5/8 - 8 3/4% | $41,978 |
| Accrued Interest | | | 705 |
| **TOTAL SMI INVESTMENTS** | | | **$42,683** |
| **TOTAL MEDICARE INVESTMENTS** | | | **$243,092** |

| FY 2000 | Maturity Range | Interest Range | Value |
|---|---|---|---|
| **HI** | | | |
| Certificates | June 2001 | 6 - 6 1/4% | $7,791 |
| Bonds | June 2001 to June 2015 | 5 7/8 - 9 1/4% | 161,068 |
| Accrued Interest | | | 2,877 |
| **TOTAL HI INVESTMENTS** | | | **$171,736** |
| **SMI** | | | |
| Certificates | June 2001 | 6 1/4% | $729 |
| Bonds | June 2001 to June 2015 | 5 7/8 - 8 3/4% | 44,346 |
| Accrued Interest | | | 755 |
| **TOTAL SMI INVESTMENTS** | | | **$45,830** |
| **TOTAL MEDICARE INVESTMENTS** | | | **$217,566** |

U.S. Treasury Special Issues are special public obligations for exclusive purchase by the Medicare trust funds. Special issues are always purchased and redeemed at face value. The face value less amounts retired to fund Medicare program expenses by the programs is the net amount outstanding reported in the Consolidating Balance Sheet. This schedule summarizes the nature and amount of investments in the Medicare Trust Funds.

# NOTE 4: INTRAGOVERNMENTAL ACCOUNTS RECEIVABLE, NET *(Dollars in Millions)*

**FY 2001**

| | Medicare HI | Medicare SMI | Medicaid | Combined Total | Intra-CMS Eliminations | Consolidated Total |
|---|---|---|---|---|---|---|
| Income Tax on Benefits (OASDI) *(see Note 5)* | $2,630 | | | $2,630 | $(2,630) | |
| Federal Matching Contributions *(see Note 5)* | | $1,592 | | 1,592 | (1,592) | |
| Medicaid Expansion SCHIP Reimbursement | | | $26 | 26 | (26) | |
| Railroad Retirement Principal | 431 | | | 431 | | $431 |
| Military Service Contribution | 123 | | | 123 | | 123 |
| **TOTAL INTRAGOVERNMENTAL ACCOUNTS RECEIVABLE, NET** | **$3,184** | **$1,592** | **$26** | **$4,802** | **$(4,248)** | **$554** |

**FY 2000**

| | Medicare HI | Medicare SMI | Medicaid | Combined Total | Intra-CMS Eliminations | Consolidated Total |
|---|---|---|---|---|---|---|
| Railroad Retirement Principal | $423 | | | $423 | | $423 |
| Military Service Contribution | 61 | | | 61 | | 61 |
| **TOTAL INTRAGOVERNMENTAL ACCOUNTS RECEIVABLE, NET** | **$484** | | | **$484** | | **$484** |

# NOTE 5: ANTICIPATED CONGRESSIONAL APPROPRIATION

CMS has recorded an $11,166 million anticipated Congressional appropriation to cover liabilities incurred as of September 30 by the Medicaid program and the Payments to the Health Care Trust Funds appropriation, as discussed below:

## *Medicaid*

Beginning in FY 1996, CMS has accrued an expense and liability for Medicaid claims incurred but not reported (IBNR) as of September 30. In FY 2001, the IBNR expense exceeded the available unexpended Medicaid appropriations in the amount of $6,944 million. A review of appropriation language by CMS's Office of General Counsel (OGC) has resulted in a determination that the Medicaid appropriation's indefinite authority

provision allows for the entire IBNR amount to be reported as a funded liability. Consequently, CMS has recorded a $6,944 million anticipated appropriation in FY 2001 for IBNR claims that exceed the available appropriation.

## Payments to the Health Care Trust Funds

The SMI program is financed primarily by the general fund appropriation, Payments to the Health Care Trust Funds, and by monthly premiums paid by beneficiaries. Section 1844 of the Social Security Act authorizes funds to be appropriated from the general fund to match premiums payable "and deposited in the Trust Fund . . . " Section 1844 also outlines the ratio for the match and the method to make the trust funds whole if insufficient funds are available in the appropriation to match all SMI premiums received in the fiscal year. The appropriated amount is an estimate calculated annually by CMS's OACT and can be insufficient in any particular fiscal year. In FY 2001, the estimate was insufficient and the matching ceased prior to the close of the fiscal year. Subsequently, OACT has valued the unmatched amount as $1,592 million. When this occurs, Section 1844 allows for a reimbursement to be made to the SMI Trust Fund from the Payments to the Health Care Trust Funds appropriation enacted for the following year. Consequently, CMS has recorded a $1,592 million anticipated appropriation in FY 2001 for the amount of the unmatched SMI premiums. Although the actual transfer of funds will occur in FY 2002, CMS has reported the $1,592 million as revenues earned in FY 2001.

In addition, CMS has recorded in the Payments to the Health Care Trust Funds appropriation a liability of $1,592 million to SMI for the unmatched SMI premiums. For reporting purposes, this liability appears under SMI Other Liabilities on the Consolidating Balance Sheet in the Supplementary Section.

In April 2001 the quarterly transfer to HI of the estimated portion of individual income tax liability from the Treasury general fund was understated by $2,630 million as a result of a Treasury clerical error in the warrant process. Public Law 103-66 Section 13215 Social Security and Tier I Railroad Retirement Benefits authorizes funds to be appropriated from the general fund equal to the increase in tax liabilities on OASDI beneficiaries and to be transferred to HI. CMS has recorded in the Payments to the Health Care Trust Funds appropriation a receivable for $2,630 million and an offsetting liability of $2,630 million to HI as a result of the Treasury error. Although the actual transfer of funds will occur in FY 2002, CMS has reported the $2,630 million as Transfers-in and -out on the Statement of Changes in Net Position. Treasury is processing an appropriate remedy for the lost HI interest earnings.

# NOTE 6: ACCOUNTS RECEIVABLE, NET *(Dollars in Millions)*

| FY 2001 | Medicare HI | Medicare SMI | Medicaid | All Others | Consolidated Total |
|---|---|---|---|---|---|
| **Provider & Beneficiary Overpayment** | | | | | |
| Accounts Receivable Principal | $4,724 | $1,539 | | $556 | $6,819 |
| Less: Allowance for Uncollectible Accounts | (2,818) | (1,054) | | (529) | (4,401) |
| Accounts Receivable, Net | 1,906 | 485 | | 27 | 2,418 |
| **Medicare Secondary Payer (MSP)** | | | | | |
| Accounts Receivable Principal | 117 | 87 | | 8 | 212 |
| Less: Allowance for Uncollectible Accounts | (49) | (43) | | (3) | (95) |
| Accounts Receivable, Net | 68 | 44 | | 5 | 117 |
| **CMPs & Other Restitutions** | | | | | |
| Accounts Receivable Principal | 138 | 273 | | 1 | 412 |
| Less: Allowance for Uncollectible Accounts | (89) | (101) | | | (190) |
| Accounts Receivable, Net | 49 | 172 | | 1 | 222 |
| **Fraud and Abuse** | | | | | |
| Accounts Receivable Principal | 104 | 118 | | | 222 |
| Less: Allowance for Uncollectible Accounts | (100) | (116) | | | (216) |
| Accounts Receivable, Net | 4 | 2 | | | 6 |
| **Managed Care** | | | | | |
| Accounts Receivable Principal | 3 | 9 | | 9 | 21 |
| Less: Allowance for Uncollectible Accounts | ___ | (3) | | | (3) |
| Accounts Receivable, Net | 3 | 6 | | 9 | 18 |
| **Medicare Premiums** | | | | | |
| Accounts Receivable Principal | 125 | 276 | | | 401 |
| Less: Allowance for Uncollectible Accounts | (29) | (24) | | | (53) |
| Accounts Receivable, Net | 96 | 252 | | | 348 |
| **Audit Disallowances** | | | | | |
| Accounts Receivable Principal | 3 | 6 | $1,146 | | 1,155 |
| Less: Allowance for Uncollectible Accounts | (1) | (1) | (197) | | (199) |
| Accounts Receivable, Net | 2 | 5 | 949 | | 956 |
| **Other Accounts Receivable** | | | | | |
| Accounts Receivable Principal | | | 23 | 1 | 24 |
| Less: Allowance for Uncollectible Accounts | ___ | ___ | (23) | | (23) |
| Accounts Receivable, Net | | | | 1 | 1 |
| **TOTAL ACCOUNTS RECEIVABLE PRINCIPAL** | **$5,214** | **$2,308** | **$1,169** | **$575** | **$9,266** |
| Less: Allowance for Uncollectible Accounts | (3,086) | (1,342) | (220) | (532) | (5,180) |
| **TOTAL ACCOUNTS RECEIVABLE, NET** | **$2,128** | **$966** | **$949** | **$43** | **$4,086** |

| FY 2000 *(Restated)* | Medicare HI | Medicare SMI | Medicaid | All Others | Consolidated Total |
|---|---|---|---|---|---|
| **Provider & Beneficiary Overpayments** | | | | | |
| Accounts Receivable Principal | $5,112 | $1,740 | | $448 | $7,300 |
| Less: Allowance for Uncollectible Accounts | (2,717) | (1,016) | | (376) | (4,109) |
| Accounts Receivable, Net | 2,395 | 724 | | 72 | 3,191 |
| **Medicare Secondary Payer (MSP)** | | | | | |
| Accounts Receivable Principal | 134 | 90 | | 38 | 262 |
| Less: Allowance for Uncollectible Accounts | (112) | (78) | | (32) | (222) |
| Accounts Receivable, Net | 22 | 12 | | 6 | 40 |
| **CMPs & Other Restitutions** | | | | | |
| Accounts Receivable Principal | 73 | 186 | | | 259 |
| Less: Allowance for Uncollectible Accounts | (51) | (26) | | | (77) |
| Accounts Receivable, Net | 22 | 160 | | | 182 |
| **Fraud and Abuse** | | | | | |
| Accounts Receivable Principal | 101 | 110 | | | 211 |
| Less: Allowance for Uncollectible Accounts | (100) | (109) | | | (209) |
| Accounts Receivable, Net | 1 | 1 | | | 2 |
| **Managed Care** | | | | | |
| Accounts Receivable Principal | 25 | 37 | | 7 | 69 |
| Less: Allowance for Uncollectible Accounts | | | | | |
| Accounts Receivable, Net | 25 | 37 | | 7 | 69 |
| **Medicare Premiums** | | | | | |
| Accounts Receivable Principal | 127 | 250 | | | 377 |
| Less: Allowance for Uncollectible Accounts | (34) | (36) | | | (70) |
| Accounts Receivable, Net | 93 | 214 | | | 307 |
| **Audit Disallowances** | | | | | |
| Accounts Receivable Principal | 2 | 6 | $92 | | 100 |
| Less: Allowance for Uncollectible Accounts | | (1) | (13) | | (14) |
| Accounts Receivable, Net | 2 | 5 | 79 | | 86 |
| **Other Accounts Receivable** | | | | | |
| Accounts Receivable Principal | | | 13 | $1 | 14 |
| Less: Allowance for Uncollectible Accounts | | | (13) | | (13) |
| Accounts Receivable, Net | | | | 1 | 1 |
| **TOTAL ACCOUNTS RECEIVABLE PRINCIPAL** | **$5,574** | **$2,419** | **$105** | **$494** | **$8,592** |
| Less: Allowance for Uncollectible Accounts | (3,014) | (1,266) | (26) | (408) | (4,714) |
| **TOTAL ACCOUNTS RECEIVABLE, NET** | **$2,560** | **$1,153** | **$79** | **$86** | **$3,878** |

Medicare accounts receivable are primarily composed of provider and beneficiary overpayments, and MSP overpayments. The MSP receivables are composed of paid claims in which Medicare should have been the secondary rather than the primary payer. Claims that have been identified to a primary payer are included in the MSP receivable amount. Accounts receivable data were primarily obtained from data provided by the Medicare contractors.

## Currently Not Reportable/Currently Not Collectible Debt

In FY 1999, CMS implemented a number of policy changes in the reporting of delinquent accounts receivable. Provisions within the Office of Management and Budget (OMB) Circular A-129, ***Managing Federal Credit Programs***, allow an agency to move certain uncollectible delinquent debts into memorandum entries, which removes the receivable from the financial statements. The policy provides for certain debts to be written off closed without any further collection activity or reclassified as Currently Not Reportable. (This is also referred to as Currently Not Reportable/Collectible). This category of debt will continue to be referred for collection and litigation, but will not be reported on the financial statements because of the unlikelihood of collecting it. While these debts are not reported on the financial statements, the Currently Not Reportable/Collectible process permits and requires the use of collection tools of the Debt Collection Improvement Act of 1996. This allows delinquent debt to be worked until the end of its statutory collection life cycle.

In FY 2001, CMS continued the implementation of this policy and again performed analyses of its accounts receivable. CMS also continued to manage this debt by referring a significant portion of debt to Treasury for offset and cross-servicing in accordance with the Debt Collection Improvement Act of 1996.

## Recognition of MSP Accounts Receivable

MSP accounts receivable are recorded on the financial statements as of the date the MSP recovery demand letter is issued. However, the MSP accounts receivable ending balance reflects an adjustment for expected reductions to group health plan accounts receivable for situations where CMS receives valid documented defenses to its recovery demands.

## Write Offs and Adjustments

The implementation of the revised policies and other initiatives undertaken in recent fiscal years resulted in significant adjustments and write offs made to CMS's accounts receivable balance. CMS's financial reporting reflected additional adjustments, resulting from the validation and reconciliation efforts performed, revised policies and supplemental guidance provided by CMS to the Medicare contractors. The accounts receivable ending balance continues to reflect adjustments for accounts receivable which have been reclassified as Currently Not Reportable debt and unfiled cost reports.

The allowance for uncollectible accounts receivable derived this year has been calculated from data based on the agency's collection activity and the age of the debt for the most current fiscal year, while taking into consideration the average uncollectible percentage for the past five years.

## Non-entity Assets

Assets are either "entity" (the reporting entity holds and has authority to use the assets in its operations) or "non-entity" (the reporting agency holds but does not have authority to use in its operations). Before FY 2000 CMS reported its entity and non-

entity assets in separate sections of the balance sheet. Since FY 2000 CMS has reported its entity and non-entity assets in a single combined section.

The only non-entity assets on CMS's Consolidating Balance Sheet are receivables for interest and penalties, net for the amount of $42 million. The accrued interest associated with Provider and Beneficiary, MSP and Managed Care overpayments appear under All Others. In FY 2000 Interest and Penalties Receivable, Net appeared on its own line; for FY 2001 this amount is included with Accounts Receivable, Net on the Consolidating Balance Sheet and under the All Others column in Note 6. The FY 2000 comparative table has been restated to reflect this change.

## NOTE 7: OTHER LIABILITIES *(Dollars in Millions)*

| FY 2001 | Medicare HI | Medicare SMI | Medicaid | SCHIP | All Others | Combined Total | Intra-CMS Eliminations | Consolidated Total |
|---|---|---|---|---|---|---|---|---|
| **Intragovernmental:** | | | | | | | | |
| Uncollected Revenue due Treasury | $54 | $117 | | | $42 | $213 | | $213 |
| Unmatched SMI Premiums *(see Note 5)* | | 1,592 | | | | 1,592 | $(1,592) | |
| Income Tax on Benefits *(see Note 5)* | 2,630 | | | | | 2,630 | (2,630) | |
| FICA Tax Adjustment | 200 | | | | | 200 | | 200 |
| SECA Tax Adjustment | 253 | | | | | 253 | | 253 |
| Other | 5 | 8 | $1 | | 18 | 32 | | 32 |
| **TOTAL OTHER INTRAGOVERNMENTAL LIABILITIES** | **$3,142** | **$1,717** | **$1** | | **$60** | **$4,920** | **$(4,222)** | **$698** |
| Deferred Revenue | $48 | $138 | | | | $186 | | $186 |
| Suspense Account Deposit Funds | | | | | $14 | 14 | | 14 |
| Other | 7 | 3 | | | | 10 | | 10 |
| **TOTAL OTHER LIABILITIES** | **$55** | **$141** | | | **$14** | **$210** | | **$210** |

| FY 2000 | Medicare HI | Medicare SMI | Medicaid | SCHIP | All Others | Consolidated Total |
|---|---|---|---|---|---|---|
| **Intragovernmental:** | | | | | | |
| Uncollected Revenue due Treasury | $68 | $101 | | | $85 | $254 |
| SECA Tax Adjustment | 158 | | | | | 158 |
| Other | 2 | 4 | $1 | | 8 | 15 |
| **TOTAL OTHER INTRAGOVERNMENTAL LIABILITIES** | **$228** | **$105** | **$1** | | **$93** | **$427** |
| Deferred Revenue | $31 | $117 | | | | $148 |
| Suspense Account Deposit Funds | | | | | $15 | 15 |
| Other | 22 | 2 | | | | 24 |
| **TOTAL OTHER LIABILITIES** | **$53** | **$119** | | | **$15** | **$187** |

## Potential Liabilities

CMS routinely processes and settles cost reports and payment issues for institutional providers and healthcare insurers. As part of this process, some providers/insurers have filed suits challenging the amount of reimbursement to which they claim entitlement. CMS cannot reasonably estimate the probability of the providers successfully winning their suits or the exact amount of the potential loss to the Medicare trust funds.

In the opinion of management, the resolution of these matters could potentially have a material impact on the results of operations and financial condition of CMS.

# NOTE 8: ENTITLEMENT BENEFITS DUE AND PAYABLE *(Dollars in Millions)*

| FY 2001 | Medicare | | | | Consolidated |
|---|---|---|---|---|---|
| | HI | SMI | Total | Medicaid | Total |
| Medicare Benefits Payable *(1)* | $13,617 | $13,464 | $27,081 | | $27,081 |
| Medicaid Benefits Payable *(2)* | | | | $13,247 | 13,247 |
| Medicaid Audit/Program Disallowances *(3)* | | | | 113 | 113 |
| **TOTAL ENTITLEMENT BENEFITS DUE AND PAYABLE** | **$13,617** | **$13,464** | **$27,081** | **$13,360** | **$40,441** |

| FY 2000 | Medicare | | | | Consolidated |
|---|---|---|---|---|---|
| | HI | SMI | Total | Medicaid | Total |
| Medicare Benefits Payable | $12,671 | $11,481 | $24,152 | | $24,152 |
| Demonstration Projects and HMO Benefits | 18 | 15 | 33 | | 33 |
| Medicaid Benefits Payable | | | | $12,235 | 12,235 |
| Medicaid Audit/Program Disallowances | | | | 96 | 96 |
| **TOTAL ENTITLEMENT BENEFITS DUE AND PAYABLE** | **$12,689** | **$11,496** | **$24,185** | **$12,331** | **$36,516** |

***(1)*** Medicare benefits payable consists of $27.1 billion estimate by CMS's Office of the Actuary of Medicare services incurred but not paid, as of September 30, 2001.

***(2)*** Medicaid benefits payable of $13.2 billion is an estimate of the net Federal share of expenses that have been incurred by the States but not yet reported to CMS as of September 30, 2001.

***(3)*** Medicaid audit and program disallowances of $113 million are contingent liabilities that have been established as a result of Medicaid audit and program disallowances that are currently being appealed by the States. In all cases, the funds have been returned to CMS. CMS will be required to pay these amounts if the appeals are decided in the favor

of the States. In addition, certain amounts for payment have been deferred under the Medicaid program when there is a reasonable doubt as to the legitimacy of expenditures claimed by a State. CMS defers the payment of these claims until the State provides additional supporting data. Based on historical data, CMS expects to eventually pay approximately 14.1 percent of total contingent liabilities. Therefore, of the total contingent liabilities of $799 million, CMS expects to pay approximately $113 million.

### Appeals at the Provider Reimbursement Review Board

Other liabilities do not include all provider cost reports under appeal at the Provider Reimbursement Review Board (PRRB). The monetary effect of those appeals is generally not known until a decision is rendered. As of September 30, 2000, there were 10,244 PRRB cases under appeal. A total of 3,586 new cases were filed in FY 2001. The PRRB rendered decisions on 55 cases in FY 2001 and 3,633 additional cases were dismissed, withdrawn or settled prior to an appeal hearing. The PRRB gets no information on the value of these cases that are settled prior to a hearing. Since data is available for only the 55 cases that were decided in FY 2001, a reasonable liability estimate cannot be projected for the value of the 10,142 cases remaining on appeal as of September 30, 2001. As cases are decided, the settlement value paid is considered in the development of the actuarial liability estimate.

## NOTE 9: LIABILITIES NOT COVERED BY BUDGETARY RESOURCES *(Dollars in Millions)*

| FY 2001 | Medicare HI | Medicare SMI | Medicaid | SCHIP | All Others | Combined Total | Intra-CMS Eliminations | Consolidated Total |
|---|---|---|---|---|---|---|---|---|
| **Intragovernmental:** | | | | | | | | |
| Accrued Payroll and Benefits | $1 | $1 | | | | $2 | | $2 |
| **TOTAL INTRAGOVERNMENTAL** | **$1** | **$1** | | | | **$2** | | **$2** |
| Entitlement Benefits Due and Payable | | | $7,779 | | | $7,779 | | $7,779 |
| Federal Employee and Veterans' Benefits | $3 | $6 | 1 | | | 10 | | 10 |
| Accrued Payroll and Benefits | 8 | 18 | 2 | | | 28 | | 28 |
| **TOTAL LIABILITIES NOT COVERED BY BUDGETARY RESOURCES** | **$12** | **$25** | **$7,782** | | | **$7,819** | | **$7,819** |
| Total Liabilities Covered by Budgetary Resources | $16,825 | $15,339 | $5,583 | $26 | $74 | $37,847 | $(4,248) | $33,599 |
| **TOTAL LIABILITIES** | **$16,837** | **$15,364** | **$13,365** | **$26** | **$74** | **$45,666** | **$(4,248)** | **$41,418** |

| FY 2000 | Medicare HI | Medicare SMI | Medicaid | SCHIP | All Others | Consolidated Total |
|---|---|---|---|---|---|---|
| **Intragovernmental:** | | | | | | |
| Accrued Payroll and Benefits | $1 | $3 | | | | $4 |
| **TOTAL INTRAGOVERNMENTAL** | **$1** | **$3** | | | | **$4** |
| Entitlement Benefits Due and Payable | | | $6,641 | | | $6,641 |
| Federal Employee and Veterans' Benefits | $3 | $6 | 1 | | | 10 |
| Accrued Payroll and Benefits | 8 | 17 | 2 | | | 27 |
| **TOTAL LIABILITIES NOT COVERED BY BUDGETARY RESOURCES** | **$12** | **$26** | **$6,644** | | | **$6,682** |
| Total Liabilities Covered by Budgetary Resources | $13,006 | $11,753 | $5,694 | | $108 | $30,561 |
| **TOTAL LIABILITIES** | **$13,018** | **$11,779** | **$12,338** | | **$108** | **$37,243** |

# NOTE 10: UNEXPENDED APPROPRIATIONS *(Dollars in Millions)*

| FY 2001 | Medicare HI | Medicare SMI | Medicaid | SCHIP | All Others | Consolidated Total |
|---|---|---|---|---|---|---|
| **Unobligated** | | | | | | |
| Available | | | | | $66 | $66 |
| Unavailable | $3 | | | | | 3 |
| **Undelivered Orders** | | | | $11,475 | 20 | 11,495 |
| **TOTAL UNEXPENDED APPROPRIATIONS** | **$3** | | | **$11,475** | **$86** | **$11,564** |

| FY 2000 | Medicare HI | Medicare SMI | Medicaid | SCHIP | All Others | Consolidated Total |
|---|---|---|---|---|---|---|
| **Unobligated** | | | | | | |
| Available | | | | | $11 | $11 |
| Unavailable | $13 | $3,129 | | | | 3,142 |
| **Undelivered Orders** | | | | $10,951 | 15 | 10,966 |
| **TOTAL UNEXPENDED APPROPRIATIONS** | **$13** | **$3,129** | | **$10,951** | **$26** | **$14,119** |

# NOTE 11: MEDICARE BENEFIT PAYMENTS

## Medicare Claims Estimated Improper Payments

Federal government audits require the review of programs for compliance with Federal laws and regulations. Accordingly, the OIG reviewed a statistically valid sample of Medicare claims to determine that claims were paid properly by Medicare contractors, and that services were actually performed and were medically necessary. Medicare, like other insurers, makes payments based on a standard claims form. The internal claims process involves reviewing claims as billed and paying the correct amount for the services rendered. The claims submitted for payment to Medicare contractors contained no visible errors. However, when the medical review asked for documentation from providers to support their claims, there was a 6.3 percent error rate with a dollar value in the range of $7.2–$16.9 billion ($12.1 billion point estimate). The majority of the errors fell into four broad categories: lack of medical necessity, insufficient or no documentation, incorrect coding, and noncovered/unallowable services.

## Cost Report Settlement Process

The cost report settlement process represents the value of final outlays to providers based on fiscal intermediary (FI) audits, reviews and final settlements of Medicare cost reports. All institutional providers are required to file Medicare cost reports. For providers paid

under the prospective payment system (PPS), the cost report includes costs that are not covered under PPS, such as disproportionate share hospital payments, indirect medical education payments, and other indirect costs. For providers paid on a cost basis, the cost report represents the total costs incurred by the provider for medical services to patients and reflects the final distribution of these costs to the Medicare program.

In 2001, 34,118 cost reports totaling $92.7 billion were reviewed. Approximately $74.4 billion represented inpatient claims to PPS providers. These inpatient claims were included in prior years' claims testing that resulted in the determination of the Medicare claims improper payment error rate. The cost report settlements, therefore, focused on the remaining non-PPS balance of about $18.3 billion.

### 2001 Cost Report Summary

(Dollars in millions)

| | Desk Reviews and Other | Audits | Total |
|---|---|---|---|
| **Cost Reports** | 30,393 | 3,725 | 34,118 |
| **Costs Claimed** | $36,810 | $55,891 | $92,701 |
| **Disallowed** | $407 | $350 | $757 |

### 2000 Cost Report Summary

(Dollars in millions)

| | Desk Reviews and Other | Audits | Total |
|---|---|---|---|
| **Cost Reports** | 28,923 | 5,653 | 34,576 |
| **Costs Claimed** | $40,713 | $63,027 | $103,740 |
| **Disallowed** | $857 | $1,449 | $2,306 |

The $757 million disallowed represents 4 percent of the $18.3 billion non-PPS balance. Based on the current disallowance rates, if the full-scope audits were expanded to include the entire universe, the total amount disallowed would range from $757 million to $1.3 billion. Therefore, by limiting the amount of full-scope audits that were conducted, CMS may have overpaid providers by as much as $493 million.

# NOTE 12: TOTAL PROGRAM/ACTIVITY COSTS *(Dollars in Millions) (By Object Class)*

| FY 2001 | Medicare HI | Medicare SMI | Medicare | Medicaid | SCHIP | All Others | Combined Totals | Intra-CMS Eliminations | Consolidated Total |
|---|---|---|---|---|---|---|---|---|---|
| **PROGRAM COSTS** | | | | | | | | | |
| **Medicare** | | | | | | | | | |
| Insurance Claims and Indemnities | | | | | | | | | |
| Fee for Service | $117,503 | $80,285 | $197,788 | | | | $197,788 | | $197,788 |
| Managed Care | 22,836 | 19,176 | 42,012 | | | | 42,012 | | 42,012 |
| **Medicaid/SCHIP/TWI** | | | | | | | | | |
| Grants and Subsidies | | | | $130,232 | $3,725 | $2 | 133,959 | $(1,239) | 132,720 |
| **TOTAL PROGRAM COSTS** | **$140,339** | **$99,461** | **$239,800** | **$130,232** | **$3,725** | **$2** | **$373,759** | **$(1,239)** | **372,520** |
| **OPERATING COSTS** | | | | | | | | | |
| Administrative | | | | | | | | | |
| Personal Services and Benefits | $141 | $194 | $335 | $33 | | | $368 | | $368 |
| Contractual Services | 756 | 980 | 1,736 | 156 | $1 | | 1,893 | | 1,893 |
| Grants and Subsidies | 9 | 16 | 25 | 3 | | | 28 | | 28 |
| Travel and Transportation | 3 | 6 | 9 | 1 | | | 10 | | 10 |
| Rental and Utilities | 15 | 29 | 44 | 5 | | | 49 | | 49 |
| Printing and Reproduction | 1 | 3 | 4 | | | | 4 | | 4 |
| Supplies and Materials | 1 | 2 | 3 | | | | 3 | | 3 |
| Equipment | 5 | 8 | 13 | 2 | | | 15 | | 15 |
| **TOTAL ADMINISTRATIVE COSTS** | **$931** | **$1,238** | **$2,169** | **$200** | **$1** | | **$2,370** | | **$2,370** |
| Depreciation and Amortization | $2 | $3 | $5 | $1 | | | $6 | | $6 |
| Bad Debts and Writeoffs | 76 | 88 | 164 | 10 | | | 174 | | 174 |
| Medicare Integrity Program | 905 | | 905 | | | | 905 | | 905 |
| Imputed Cost Subsidies | 8 | 16 | 24 | 3 | | | 27 | | 27 |
| CLIA Program Costs | | | | | | $143 | 143 | | 143 |
| Reimbursable Costs | | | | | | 4 | 4 | | 4 |
| Other Costs | 14 | 26 | 40 | 4 | | | 44 | | 44 |
| **TOTAL COSTS** | **$142,275** | **$100,832** | **$243,107** | **$130,450** | **$3,726** | **$149** | **$377,432** | **$(1,239)** | **$376,193** |
| **Less: EARNED REVENUES** | | | | | | | | | |
| Premiums Collected | $(1,439) | $(22,307) | $(23,746) | | | | $(23,746) | | $(23,746) |
| Other Earned Revenues | (4) | | (4) | $(1,239) | | $(62) | (1,305) | $1,239 | (66) |
| **NET COST OF OPERATIONS** | **$140,832** | **$78,525** | **$219,357** | **$129,211** | **$3,726** | **$87** | **$352,381** | | **$352,381** |

| FY 2000 | Medicare HI | Medicare SMI | Medicare | Medicaid | SCHIP | Total CLIA | All Others | Consolidated Total |
|---|---|---|---|---|---|---|---|---|
| PROGRAM COSTS | | | | | | | | |
| Medicare | | | | | | | | |
| Insurance Claims and Indemnities | | | | | | | | |
| Fee for Service | $105,446 | $69,462 | $174,908 | | | | | $174,908 |
| Managed Care | 21,495 | 18,332 | 39,827 | | | | | 39,827 |
| Medicaid and SCHIP | | | | | | | | |
| Grants and Subsidies | | | | $118,564 | $1,268 | | | 119,832 |
| **TOTAL PROGRAM COSTS** | **$126,941** | **$87,794** | **$214,735** | **$118,564** | **$1,268** | | | **$334,567** |
| OPERATING COSTS | | | | | | | | |
| Administrative | | | | | | | | |
| Personal Services and Benefits | $139 | $184 | $323 | $21 | $1 | | | $345 |
| Contractual Services | 734 | 966 | 1,700 | 103 | 4 | | | 1,807 |
| Grants and Subsidies | 6 | 11 | 17 | 1 | | | | 18 |
| Travel and Transportation | 4 | 6 | 10 | 1 | | | | 11 |
| Rental and Utilities | 11 | 21 | 32 | 2 | | | | 34 |
| Printing and Reproduction | 2 | 3 | 5 | | | | | 5 |
| Supplies and Materials | 1 | 2 | 3 | | | | | 3 |
| Equipment | 7 | 12 | 19 | 1 | | | | 20 |
| **TOTAL ADMINISTRATIVE COSTS** | **$904** | **$1,205** | **$2,109** | **$129** | **$5** | | | **$2,243** |
| Depreciation and Amortization | $2 | $4 | $6 | $1 | | | | $7 |
| Bad Debts and Writeoffs | 608 | 568 | 1,176 | 6 | | | | 1,182 |
| Medicare Integrity Program | 865 | | 865 | | | | | 865 |
| Imputed Cost Subsidies | 7 | 15 | 22 | 2 | | | | 24 |
| CLIA Program Costs | | | | | | $122 | | 122 |
| Reimbursable Costs | | | | | | | $8 | 8 |
| Other Costs | 14 | 25 | 39 | 3 | | | | 42 |
| **TOTAL COSTS** | **$129,341** | **$89,611** | **$218,952** | **$118,705** | **$1,273** | **$122** | **$8** | **$339,060** |
| Less: EARNED REVENUES | | | | | | | | |
| Premiums Collected | $(1,392) | $(20,515) | $(21,907) | | | | | $(21,907) |
| Other Earned Revenues | (4) | | (4) | | | $(140) | $(3) | (147) |
| **NET COST OF OPERATIONS** | **$127,945** | **$69,096** | **$197,041** | **$118,705** | **$1,273** | **$(18)** | **$5** | **$317,006** |

For purposes of financial statement presentation, non-CMS administrative costs are considered expenses to the Medicare Trust Funds when outlayed by Treasury even though some funds may have been used to pay for assets such as property and equipment. In this regard, the SSA reported $75.4 million of Property and Equipment, (Net) attributable to the Medicare program as of September 30, 2001. This amount is not included in CMS's Consolidating Balance Sheet as assets related to the Medicare program. However, funds withdrawn from the trust funds by SSA during FY 2001 to pay for this activity are reported as Transfers-Out in the Statement of Changes in Net Position. The SSA administrative costs are reported to CMS by Treasury. These expenses are also reported by SSA on their FY 2001 Annual Financial Statement. CMS's administrative costs have been allocated to the Medicare, Medicaid, SCHIP and TWI programs based on the CMS cost allocation system. Administrative costs allocated to the

Medicare program include $1.0 billion paid to Medicare contractors to carry out their responsibilities as CMS's agents in the administration of the Medicare program.

The chart below details the Administrative Expenses by agency. CMS is only one of several agencies that charge some administrative expenses to Medicare.

## Administrative Expenses

(Dollars in millions)

| FY 2001 | Medicare | | | | | Consolidated |
|---|---|---|---|---|---|---|
| | HI | SMI | Total | Medicaid | SCHIP | Total |
| **Administrative Expenses by Agency** | | | | | | |
| Treasury | $40 | | $40 | | | $40 |
| CMS | 617 | $1,183 | 1,800 | $200 | $1 | 2,001 |
| Peer Review Organizations | 274 | 55 | 329 | | | 329 |
| **TOTAL ADMINISTRATIVE EXPENSES** | **$931** | **$1,238** | **$2,169** | **$200** | **$1** | **$2,370** |

## Administrative Expenses

(Dollars in millions)

| FY 2000 | Medicare | | | | | Consolidated |
|---|---|---|---|---|---|---|
| | HI | SMI | Total | Medicaid | SCHIP | Total |
| **Administrative Expenses by Agency** | | | | | | |
| Treasury | $40 | | $40 | | | $40 |
| CMS | 629 | $1,161 | 1,790 | $129 | $5 | 1,924 |
| Peer Review Organizations | 235 | 44 | 279 | | | 279 |
| **TOTAL ADMINISTRATIVE EXPENSES** | **$904** | **$1,205** | **$2,109** | **$129** | **$5** | **$2,243** |

# NOTE 13: TAXES AND OTHER NON-EXCHANGE REVENUE *(Dollars in Millions)*

| FY 2001 | Medicare HI | Medicare SMI | Medicaid | SCHIP | All Others | Consolidated Total |
|---|---|---|---|---|---|---|
| FICA Tax Receipts | $140,695 | | | | | $140,695 |
| SECA Tax Receipts | 9,627 | | | | | 9,627 |
| Trust Fund Investment Interest | 12,733 | $3,137 | | | | 15,870 |
| Deposits by States | | | | | | |
| Criminal Fines | 3 | | | | | 3 |
| Civil Monetary Penalties and Damages | 447 | | | | | 447 |
| Administrative Fees | 13 | | | | | 13 |
| Other Income | 1 | 2 | | | | 3 |
| **TAXES AND OTHER NON-EXCHANGE REVENUE** | **$163,519** | **$3,139** | | | | **$166,658** |

For periods after December 31, 1993, employees and employers are each required to contribute 1.45 percent of employees' wages, and self-employed persons are required to contribute 2.90 percent of net income, with no limitation, to the HI Trust Fund. The Social Security Act requires the transfer of these contributions from the General Fund of Treasury to the HI Trust Fund based on the amount of wages certified by the Commissioner of Social Security from SSA records of wages established and maintained by SSA in accordance with wage information reports. The SSA uses the wage totals reported annually by employers via the quarterly Internal Revenue Service Form 941 as the basis for conducting quarterly certification of regular wages.

# NOTE 14: FEDERAL MATCHING CONTRIBUTIONS

SMI benefits and administrative expenses are financed by monthly premiums paid by Medicare beneficiaries and are matched by the Federal government through the general fund appropriation, Payments to the Health Care Trust Funds. Section 1844 of the Social Security Act authorizes appropriated funds to match SMI premiums collected, and outlines the ratio for the match as well as the method to make the trust funds whole if insufficient funds are available in the appropriation to match all premiums received in the fiscal year. The monthly SMI premium per beneficiary was $45.50 from October 2000 through December 2000 and $50.00 from January 2001 through September 2001. Premiums collected from beneficiaries totaled $22.3 billion and were matched by a $71.4 billion contribution from the Federal government.

# NOTE 15: OTHER TRANSFERS-IN/OUT *(Dollars in Millions)*

**FY 2001**

**Transfers-In**

| | Medicare HI | Medicare SMI | Medicaid | Combined Total | Intra-CMS Eliminations | Consolidated Total |
|---|---|---|---|---|---|---|
| Fraud and Abuse Appropriation | $88 | | | $88 | $(88) | |
| Transfer-Uninsured Coverage | 453 | | | 453 | (453) | |
| Program Management Admin. Expense *(1)* | 149 | | | 149 | (149) | |
| Military Service Contribution | 64 | | | 64 | | $64 |
| Income Tax OASDI Benefits *(2)* | 7,533 | | | 7,533 | (7,533) | |
| Railroad Retirement Principal | 431 | | | 431 | | 431 |
| Medicaid Part B Premiums | | | $60 | 60 | (60) | |
| Gifts and Miscellaneous | 1 | $1 | | 2 | | 2 |
| **TOTAL OTHER TRANSFERS-IN** | **$8,719** | **$1** | **$60** | **$8,780** | **$(8,283)** | **$497** |

**FY 2001**

**Transfers-Out**

| | Medicare HI | Medicare SMI | Medicaid | Combined Total | Intra-CMS Eliminations | Consolidated Total |
|---|---|---|---|---|---|---|
| SSA Administrative Expenses: Annual Year | $(537) | $(479) | | $(1,016) | | $(1,016) |
| SSA Administrative Expenses: No Year | (17) | (12) | | (29) | | (29) |
| Medicaid Part B Premiums | | (60) | | (60) | $60 | |
| Quinquennial Adjustment *(3)* | (1,177) | | | (1,177) | | (1,177) |
| Office of the Secretary | (3) | (2) | | (5) | | (5) |
| Payment Assessment Commission | (5) | (3) | | (8) | | (8) |
| Railroad Retirement Board | | (4) | | (4) | | (4) |
| **TOTAL OTHER TRANSFERS-OUT** | **$(1,739)** | **$(560)** | | **$(2,299)** | **$60** | **$(2,239)** |

***(1)*** During FY 2001, the Payments to the Health Care Trust Funds appropriation paid the HI Trust Fund $149 million to cover the Medicaid, SCHIP and TWI programs' share of CMS's administrative costs.

***(2)*** The Omnibus Budget Reconciliation Act of 1993 increased the maximum percentage of Old Age Survivors and Disability Insurance (OASDI) benefits that are subject to Federal income taxation under certain circumstances from 50 percent to 85 percent. The revenues, resulting from this increase, are transferred to the HI Trust Fund.

***(3)*** In FY 2001, $1.18 billion was transferred from the HI Trust Fund to the general fund of the Treasury for costs attributable to noncontributory wage credits for military service performed before January 1, 1957. The Social Security Amendments of 1983 (Section 217(g) of the Social Security Act) require that these costs be recomputed every 5 years. This amount represents the estimated present value of all past and future HI costs attributable to pre-1957 military service wage credits, less the accumulated value of past reimbursements.

Funds are obtained from the HI and SMI Trust Funds as cash is needed to pay for Program Management appropriation expenses. During FY 2001, a total of $2,265 million was obtained from the trust funds to cover cash outlays. Of this amount, $1,719 million was needed to pay for expenses incurred against current year obligations and $546 million (of which $22 million was transferred to the CLIA program) was needed for expenses incurred against prior year obligations.

## NOTE 16: INCREASE (DECREASE) IN UNEXPENDED APPROPRIATIONS *(Dollars in Millions)*

| FY 2001 | Medicare HI | Medicare SMI | Medicaid | SCHIP | All Others | Consolidated Total |
|---|---|---|---|---|---|---|
| Current Year Warrants and Anticipated Appropriations Exceeding (Less Than) Appropriated Capital Used | $(10) | $(3,129) | | $524 | $60 | $(2,555) |
| **TOTAL INCREASE (DECREASE) IN UNEXPENDED APPROPRIATIONS** | **$(10)** | **$(3,129)** | | **$524** | **$60** | **$(2,555)** |

In FY 2001 the Payments to the Health Care Trust Funds returned $3,139 million (the unused portion of the FY 2000 appropriation) to the Treasury general fund. The SCHIP and TWI appropriations exceeded expenditures by $524 million and $60 million, respectively.

## NOTE 17: GROSS COST AND EXCHANGE REVENUE BY BUDGET FUNCTIONAL CLASSIFICATION *(Dollars in Millions)*

| FY 2001 | Medicare | Health | Combined Total | Intra-CMS Eliminations | Consolidated Total |
|---|---|---|---|---|---|
| Intragovernmental Costs | $306 | $1,280 | $1,586 | $(1,239) | $347 |
| With the Public | 242,801 | 133,045 | 375,846 | | 375,846 |
| Gross Cost | 243,107 | 134,325 | 377,432 | | 376,193 |
| Less: Exchange Revenue | (23,750) | (1,301) | (25,051) | 1,239 | (23,812) |
| **NET COST** | **$219,357** | **$133,024** | **$352,381** | | **$352,381** |

| FY 2000 | Medicare | Health | Combined Total | Intra-CMS Eliminations | Consolidated Total |
|---|---|---|---|---|---|
| Intragovernmental Costs | $247 | $29 | $276 | | $276 |
| With the Public | 218,705 | 120,079 | 338,784 | | 338,784 |
| Gross Cost | 218,952 | 120,108 | 339,060 | | 339,060 |
| Less: Exchange Revenue | (21,911) | (143) | (22,054) | | (22,054) |
| **NET COST** | **$197,041** | **$119,965** | **$317,006** | | **$317,006** |

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services

# Required Supplementary Stewardship Information

CMS

Medicare, the largest health insurance program in the country, has helped fund medical care for the nation's aged and disabled for more than three decades. A brief description of the provisions of Medicare's Hospital Insurance (HI) and Supplementary Medical Insurance (SMI) programs is included on pages 3–4 of this financial report.

The required supplementary stewardship information (RSSI) contained in the following sections is presented in accordance with the requirements of the Federal Accounting Standards Advisory Board (FASAB). Included are a description of the long-term sustainability and financial condition of the program and a discussion of trends revealed in the data.

RSSI material is generally drawn from the ***2001 Annual Report of the Board of Trustees of the Federal Hospital Insurance Trust Fund*** and the ***2001 Annual Report of the Board of Trustees of the Federal Supplementary Medical Insurance Trust Fund***, which represent the official government evaluation of the financial and actuarial status of the Medicare Trust Funds. Unless otherwise noted, all data are for calendar years, and all projections are based on the Trustees' intermediate set of assumptions.

Printed copies of the Trustees Reports may be obtained from CMS's Office of the Actuary (410-786-6386). The reports are also available online at **www.hcfa.gov/pubforms/tr/hi2001/toc.htm** and **www.hcfa.gov/pubforms/tr/smi2001/toc.htm**.

Please note that the 2001 Trustees Reports for HI and SMI (issued March 19, 2001) were used as source documents for this FY 2001 CFO Financial Report. As this report goes to print, we anticipate that the Government-wide financial statement report for FY 2001 (expected to be issued March 31, 2002) will contain updated information from the 2002 Trustees Reports (which are expected to be issued on or near March 15, 2002). Thus, some data related to the Medicare Trust Funds contained in this FY 2001 CFO Financial Report may differ from that contained in the FY 2001 Financial Report of the United States Government.

# ACTUARIAL PROJECTIONS

## Cashflow in Nominal Dollars

Using nominal dollars[1] for short-term projections paints a reasonably clear picture of expected performance with particular attention on cashflow and trust fund balances. Over longer periods, however, the changing value of the dollar can complicate efforts to compare dollar amounts in different periods and can create severe barriers to interpretation, since projections must be linked to something that the mind can comprehend in today's experience.

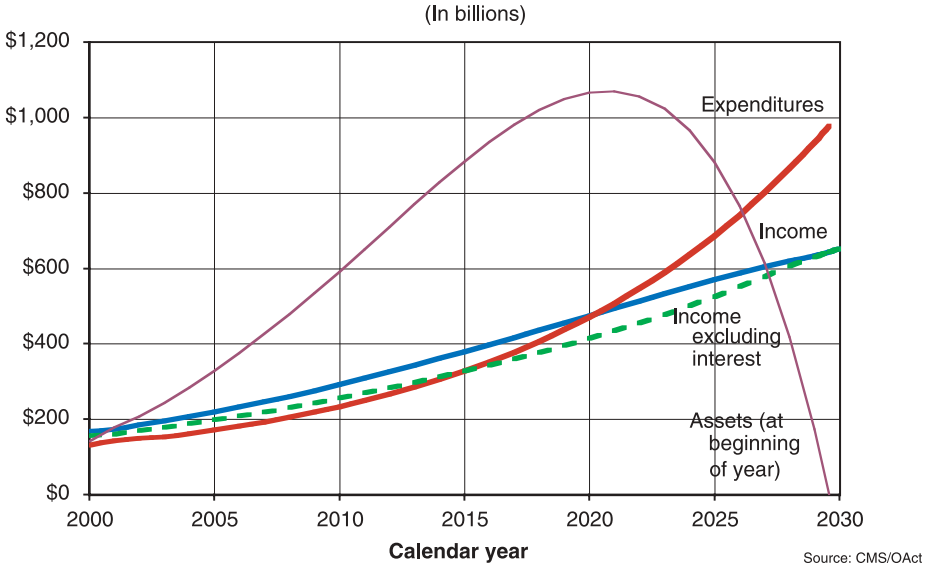
[1] Dollar amounts that are not adjusted for inflation or other factors are referred to as "nominal."

For this reason, long-range (75-year) Medicare projections in nominal dollars are seldom used and are not presented here. Instead, nominal-dollar estimates for the HI trust fund are displayed only through the projected date of depletion, currently the year 2029. Estimates for the SMI program are presented only for the next 10 years, primarily due to the fact that under present law, the SMI trust fund is in automatic financial balance every year.

## HI

Chart 1 shows the actuarial estimates of HI income, disbursements, and assets for each of the next 30 years, in nominal dollars. Income includes payroll taxes, income from the taxation of Social Security benefits, interest earned on the U.S. Treasury securities held by the trust fund, and other miscellaneous revenue. Disbursements include benefit payments and administrative expenses. The estimates are for the "open group" population—all persons who will participate in the program during the period as either taxpayers or beneficiaries, or both—and consist of payments from, and on behalf of, employees now in the workforce, as well as those who will enter the workforce over the next 30 years. The estimates also include expenditures attributable to these current and future workers, in addition to current beneficiaries.

**Chart 1—HI Income, Expenditures, and Assets 2000-2030**




Source: CMS/OAct

As chart 1 shows, under the intermediate assumptions HI expenditures would begin to exceed income including interest in 2021 and income excluding interest in 2016. This situation is in part due to the retirement, starting in 2010, of those born during the 1946–1965 baby boom. It also arises as a result of health cost increases that are expected to continue to grow faster than workers' earnings. Beginning in 2021, the trust fund would start redeeming trust fund assets; in 2029, the assets would be depleted.

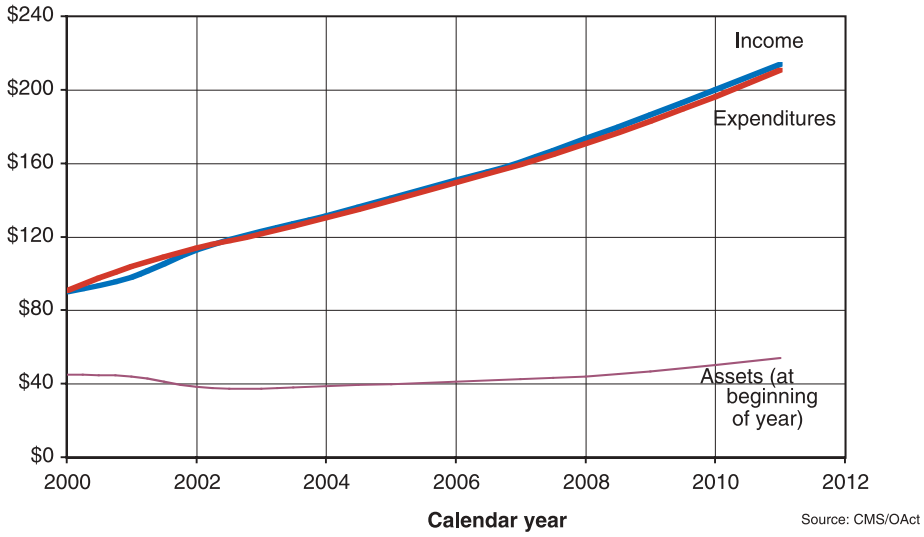
The projected year of depletion of the trust fund is very sensitive to assumed future economic and other trends. Under less favorable conditions the cash flow could turn negative much earlier and thereby accelerate asset exhaustion.

## SMI

Chart 2 shows the actuarial estimates of SMI income, disbursements, and assets for each of the next 10 years, in nominal dollars. Whereas HI estimates are displayed through the year 2030, SMI estimates cover only the next 10 years, as the SMI program differs fundamentally from the HI program in regard to the way it is financed. In particular, SMI financing is not at all based on payroll taxes but instead on monthly premiums and income from the general fund of the U.S. Treasury—both of which are established annually to cover the following year's expenditures. Estimates of SMI income and expenditures, therefore, are virtually the same, as illustrated in chart 2, and so are not shown separately beyond 10 years.

Income includes monthly premiums paid by, or on behalf of, beneficiaries, transfers from the general fund of the U.S. Treasury, and interest earned on the U.S. Treasury securities held by the trust fund.[2] Chart 2 displays only total income; it does not represent income excluding interest. The difference between the two is not visible

**Chart 2—SMI Income, Expenditures and Assets**
**2000 - 2011**
(In billions)




Source: CMS/OAct

graphically since interest is not a significant source of income.[3] Disbursements include benefit payments as well as administrative expenses.

[2] In this financial statement for the Centers for Medicare & Medicaid Services, Medicare income and expenditures are shown from a "trust fund perspective." All sources of income to the trust funds are reflected, and the actuarial projections can be used to assess the financial status of each trust fund. Corresponding estimates for Medicare and other Federal social insurance programs are also shown in the annual *Financial Report of the United States Government*, also known as the consolidated financial statement. On a consolidated basis, the estimates are shown from a "Federal budget" perspective. In particular, certain categories of trust fund income—primarily interest payments and SMI general revenues—are excluded because they represent intragovernmental transfers, rather than revenues received from the public. Thus, the consolidated financial statement focuses on the overall balance between revenues and outlays for the Federal budget, rather than on the financial status of individual trust funds. Each perspective is appropriate and useful for its intended purpose.

[3] Interest income is generally about 4 percent of total SMI income.

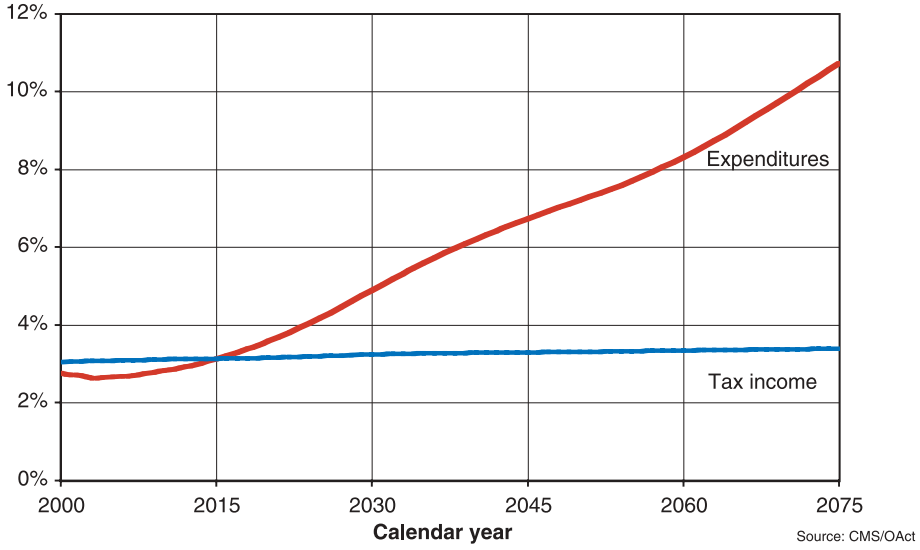
As chart 2 indicates, SMI income is very close to expenditures. As noted earlier, this is due to the financing mechanism of the SMI program. Consequently, under present law, the SMI program is automatically in financial balance every year, regardless of future economic and other conditions.

By law, Medicare Trust Fund assets are invested in special U.S. Treasury Securities, which earn interest while Treasury uses those cash resources for other Federal purposes. During times of Federal "on-budget" surpluses, such as fiscal year 2000, this process reduces the Federal debt held by the public. In times of Federal budget deficits, Medicare surpluses reduce the amount that must be borrowed from the public to finance those deficits. The Trust Fund assests are claims on the Treasury that, when redeemed, will have to be financed by raising taxes, borrowing from the public, or reducing other Federal expenditures. (When financed by borrowing, the effect is to defer today's costs to later generations who will ultimately repay the funds being borrowed for today's Medicare beneficiaries.) The existence of large trust fund balances, therefore, represents an important obligation for the Government to pay future Medicare benefits but does not necessarily make it easier for the Government to pay those benefits.

## HI Cashflow as a Percent of Taxable Payroll

Each year, estimates of the financial and actuarial status of the HI program are prepared for the next 75 years. Because of the difficulty in comparing dollar values for different periods without some type of relative scale, income and expenditure amounts are shown relative to the earnings in covered employment that are taxable under the HI program (referred to as "taxable payroll").

**Chart 3—HI Income Excluding Interest and Expenditures as a Percentage of Taxable Payroll 2000 - 2075**




Source: CMS/OAct

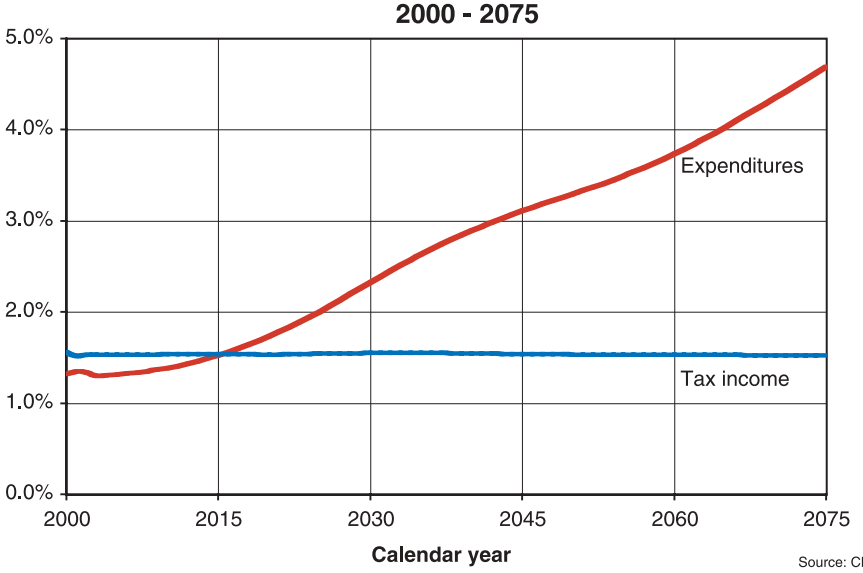
Chart 3 illustrates income excluding interest and expenditures as a percent of taxable payroll over the next 75 years. In the 2001 Trustees Reports, the long-range cost growth assumptions underlying these financial projections have been revised upward. This change was based on the recommendation of the 2000 Medicare Technical Review Panel, an independent, expert group of actuaries and economists convened by the Trustees to review the Medicare projections. In prior Trustees Reports, per beneficiary HI expenditures were assumed to increase at the same rate as average hourly earnings in the economy. Beginning with the projections shown in the 2001 report, the long-range growth assumption is increased to the level of per capita GDP growth plus 1 percentage point—which is approximately 1 percentage point per year faster than the prior assumption. As a result, after 2030 the HI expenditures as a percent of taxable payroll are projected to be substantially greater than those shown in the 2000 report.

Since HI payroll tax rates are not scheduled to change in the future under present law, payroll tax income as a percentage of taxable payroll will remain constant at 2.90 percent. Income from taxation of benefits will increase only gradually as a greater proportion of Social Security beneficiaries become subject to such taxation over time. Thus, as chart 3 shows, the income rate is not expected to increase significantly over current levels. On the other hand, expenditures as a percent of taxable payroll sharply escalate—in part due to health care cost increases that exceed wage growth, but also due to the retirement of those born during the 1946–1965 baby boom.

## HI and SMI Cashflow as a Percent of GDP

Expressing Medicare incurred disbursements as a percentage of the gross domestic product (GDP) gives a relative measure of the size of the Medicare program compared to the general economy. The GDP represents the total value of goods and services produced in the United States. This measure provides an idea of the relative financial resources that will be necessary to pay for Medicare services.

**Chart 4—HI Income Excluding Interest and Expenditures as a Percent of GDP 2000 - 2075**




Source: CMS/OAct

## HI

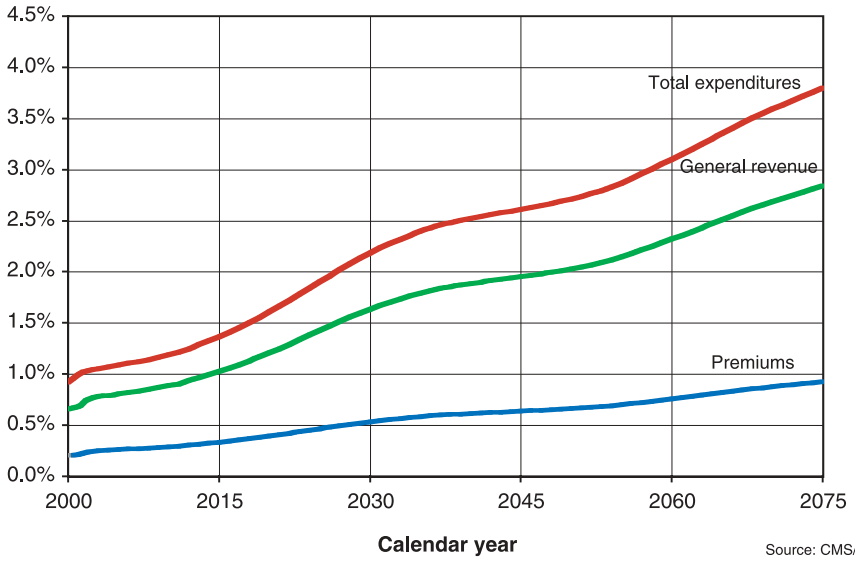
Chart 4 shows income excluding interest and expenditures for the HI program over the next 75 years expressed as a percentage of GDP. In 2000, the expenditures were $131.1 billion, which was 1.32 percent of GDP. This percentage is projected to increase steadily throughout the entire 75-year period.

## SMI

As noted earlier, because of the SMI financing mechanism in which income mirrors expenditures, it is not necessary to test for imbalances between income and expenditures. Rather, it is more important to examine the projected rise in expenditures and the implications for beneficiary premiums and Federal general revenue payments.

Chart 5 shows expenditures for the SMI program over the next 75 years expressed as a percentage of GDP. In 2000, SMI expenditures were $90.7 billion, which was 0.92 percent of GDP. This percentage is projected to increase steadily, reflecting growth in the volume and intensity of services provided per beneficiary throughout the projection period, together with the effects of the baby boom retirement.

**Chart 5—SMI Expenditures as a Percent of GDP**
**2000 - 2075**




Source: CMS/OAct

The SMI expenditure projections, like those for HI, reflect the 2000 Medicare Technical Review Panel's recommended change to the assumed long-range growth rates. In past Trustees Reports, growth in SMI per beneficiary expenditures was assumed to gradually slow and to reach the level of per capita GDP growth after about 25 years. In this report, the long-range growth rate assumption is set equal to per capita GDP growth plus 1 percentage point. Expenditure growth for years 13 to 25 is assumed to decline gradually and to grade smoothly into the long-range assumptions.

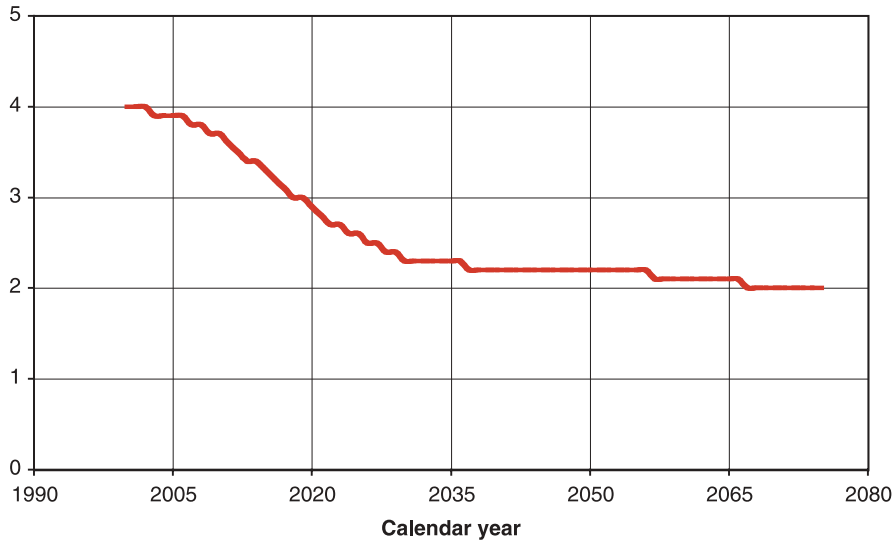
Also shown in chart 5 are the proportions of total costs that will be met through beneficiary premiums and general revenues under present law.[4] As indicated, premiums will cover roughly 25 percent of total expenditures. Both sources of revenue would increase more rapidly than the GDP over time, to match the faster growth rates for SMI expenditures.

## Worker-to-Beneficiary Ratio

### *HI*

Another way to evaluate the long-range outlook of the HI program is to examine the projected number of workers per HI beneficiary. Chart 6 illustrates this ratio over the next 75 years. For the most part, current benefits are paid for by current workers. The retirement of the baby boom generation will therefore be financed by the relatively smaller number of persons born after the baby boom. In 2000, every beneficiary had 4.0 workers to pay for his or her benefit. In 2030, however, after the last baby boomer turns 65, there will be only about 2.3 workers per beneficiary. The projected ratio continues to decline until there are just 2.0 workers per beneficiary in 2075.

**Chart 6—Number of Covered Workers per HI Beneficiary 2000 - 2075**




Source: CMS/OAct

# ACTUARIAL PRESENT VALUES

Projected future expenditures can be summarized by computing an "actuarial present value." This value represents the lump-sum amount that, if invested today in trust fund

[4] See footnote 2 regarding the treatment of SMI general revenue income in the consolidated financial statement of the U.S. government.

securities, would be just sufficient to pay each year's expenditures over the next 75 years, with the fund being drawn down to zero at the end of the period. Similarly, future revenues (excluding interest) can be summarized as a single, equivalent amount as of the current year.

Actuarial present values are calculated by discounting the future annual amounts of non-interest income and expenditures at the assumed rates of interest credited to the HI and SMI trust funds. Present values are computed as of the beginning of the 75-year projection period for three different groups of participants: current workers and other individuals who have not yet attained retirement age; current beneficiaries who have attained retirement age; and new entrants, or those who are expected to become participants in the future.

**TABLE 1**
**Actuarial Present Values of Hospital Insurance and Supplementary Medical Insurance Revenues and Expenditures: 75-year Projection as of January 1, 2001**
(In billions)

| | HI | | SMI[2] | |
|---|---|---|---|---|
| ***Actuarial present value[1] of estimated future income (excluding interest) received from or on behalf of:*** | **2001** | **2000** | **2001** | **2000** |
| Current participants[3] who, at the start of projection period: | | | | |
| Have not yet attained eligibility age (ages 15-64) | $4,136 | $3,757 | $7,378 | $6,109 |
| Have attained eligibility age (age 65 and over) | 113 | 97 | 1,032 | 934 |
| Those expected to become participants (under age 15) | 3,507 | 3,179 | 2,370 | 1,616 |
| All current and future participants | **$7,757** | **$7,033** | **$10,780** | **$8,659** |
| ***Actuarial present value[1] of estimated future expenditures[4] paid to or on behalf of:*** | | | | |
| Current participants[3] who, at the start of projection period: | | | | |
| Have not yet attained eligibility age (ages 15-64) | $8,568 | $6,702 | $7,415 | $6,094 |
| Have attained eligibility age (age 65 and over) | 1,693 | 1,681 | 1,159 | 1,051 |
| Those expected to become participants (under age 15) | 2,225 | 1,349 | 2,206 | 1,514 |
| All current and future participants | **$12,487** | **$9,732** | **$10,780** | **$8,659** |
| ***Actuarial present value[1] of estimated future income (excluding interest) less expenditures*** | -4,730 | -2,700 | 0 | 0 |
| Trust fund assets at start of period | 177 | 141 | 44 | 45 |
| ***Assets at start of period plus actuarial present value[1] of estimated future income (excluding interest) less expenditures*** | **$-4,553** | **$-2,558** | **$44** | **$45** |

[1] Present values are computed on the basis of the intermediate set of economic and demographic assumptions specified in the Report of the Board of Trustees for the year shown and over the 75-year projection period beginning January 1 of that year.

[2] SMI income includes premiums paid by beneficiaries and general revenue contributions made on behalf of the beneficiaries. See footnote 2 on page 87 concerning treatment of SMI general revenues in the consolidated financial statement of the U.S. government.

[3] Current participants are the "closed group" of individuals age 15 and over at the start of the period. The projection period for these current participants would theoretically cover all of their working and retirement years, a period that could be greater than 75 years in some instances. As a practical matter, the present values of future income and expenditures from/for current participants beyond 75 years are not material. The projection period for new entrants covers the next 75 years.

[4] Expenditures include benefit payments and administrative expenses.

*Note: Totals do not necessarily equal the sums of rounded components.*

Table 1 sets forth, for each of these three groups, the actuarial present values of all future HI and SMI expenditures and all future non-interest income for the next 75 years. Also shown is the net present value of cashflow, which is calculated by subtracting the actuarial present value of future expenditures from the actuarial present value of future income.

The long-range cost projections for 2001 are much higher than projected in the 2000 financial report because of the revision to the long-range Medicare expenditure growth rate assumptions. As mentioned previously, this change was recommended by the 2000 Medicare Technical Review Panel. Reflecting an expectation that the impact of advances in medical technology on health care costs will continue—both in Medicare and in the health sector as a whole—per beneficiary HI and SMI expenditures are now assumed to increase in the long range at the rate of per capita GDP growth plus 1 percentage point.

As shown in table 1, the HI program has an actuarial deficit of more than $4.5 trillion over the 75-year projection period, as compared to more than $2.5 trillion in the 2000 financial report. As noted previously, this higher long-range cost projection is the result of a revision to the long-range Medicare expenditure growth rate assumptions. SMI, on the other hand, does not have similar problems because it is in automatic financial balance every year due to its financing mechanism.

The existence of a large actuarial deficit for the HI trust fund indicates that, under reasonable assumptions as to economic, demographic, and health cost trends for the future, HI income is expected to fall substantially short of expenditures in the long range. Although the deficits are not anticipated in the immediate future, as indicated by the preceding cashflow projections, they nonetheless pose a serious financial problem for the HI program.

It is important to note that no liability has been recognized on the balance sheet for future payments to be made to current and future program participants beyond the existing unpaid Medicare claim amounts as of September 30, 2001. This is because Medicare is accounted for as a social insurance program rather than a pension program. Accounting for a social insurance program recognizes the expense of benefits when they are actually paid, or are due to be paid, because benefit payments are primarily nonexchange transactions and, unlike employer-sponsored pension benefits for employees, are not considered deferred compensation. Accrual accounting for a pension program, by contrast, recognizes retirement benefit expenses as they are earned so that the full actuarial present value of the worker's expected retirement benefits has been recognized by the time the worker retires.

# ACTUARIAL ASSUMPTIONS AND SENSITIVITY ANALYSIS

In order to make projections regarding the future financial status of the HI and SMI programs, various assumptions have to be made. First and foremost, the estimates presented here are based on the assumption that the programs will continue under

present law. In addition, the estimates depend on many economic and demographic assumptions, including changes in wages and the consumer price index (CPI), fertility rates, immigration rates, and interest rates. In most cases, these assumptions vary from year to year during the first 5 to 30 years before reaching their ultimate values for the remainder of the 75-year projection period.

Table 2 shows some of the underlying assumptions used in the projections of Medicare spending displayed in this report. Further details on these assumptions are available in the OASDI, HI, and SMI Trustees Reports for 2001. In practice, a number of specific assumptions are made for each of the different types of service provided by the Medicare program (for example, hospital care, physician services, etc.). These assumptions include changes in the utilization, volume, and intensity of each of these types of service. The per beneficiary cost increases displayed in table 2 reflect the overall impact of these more detailed assumptions.

**Table 2**
**Medicare Assumptions**

| | | | | | *Annual percentage change in:* | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | Fertility rate[1] | Net immigration | Real wage differential[2] | Wages | CPI | Real GDP | Per beneficiary cost[3] HI | Per beneficiary cost[3] SMI | Real Interest rate[4] |
| 2001 | 2.05 | 900,000 | 1.9 | 4.9 | 3.0 | 3.1 | 6.7 | 12.7 | 2.6 |
| 2005 | 2.04 | 900,000 | 1.2 | 4.4 | 3.2 | 2.3 | 4.4 | 6.2 | 2.9 |
| 2010 | 2.02 | 900,000 | 1.0 | 4.3 | 3.3 | 2.0 | 4.5 | 5.4 | 3.0 |
| 2020 | 1.97 | 900,000 | 1.0 | 4.3 | 3.3 | 1.7 | 4.6 | 5.3 | 3.0 |
| 2030 | 1.95 | 900,000 | 1.0 | 4.3 | 3.3 | 1.7 | 6.1 | 5.7 | 3.0 |
| 2040 | 1.95 | 900,000 | 1.0 | 4.3 | 3.3 | 1.7 | 6.4 | 5.5 | 3.0 |
| 2050 | 1.95 | 900,000 | 1.0 | 4.3 | 3.3 | 1.6 | 5.4 | 5.1 | 3.0 |
| 2060 | 1.95 | 900,000 | 1.0 | 4.3 | 3.3 | 1.6 | 5.5 | 5.6 | 3.0 |
| 2070 | 1.95 | 900,000 | 1.0 | 4.3 | 3.3 | 1.6 | 5.8 | 5.4 | 3.0 |
| 2075 | 1.95 | 900,000 | 1.0 | 4.3 | 3.3 | 1.6 | 5.7 | 5.3 | 3.0 |

[1] Average number of children per woman.
[2] Difference between percentage increases in wages and the CPI.
[3] See text for nature of this assumption.
[4] Average rate of interest earned on new trust fund securities, above and beyond rate of inflation.

Estimates made in prior years have sometimes changed substantially because of revisions to the assumptions, which are due either to changed conditions or to more recent experience. Furthermore, it is important to recognize that actual conditions are very likely to differ from the projections presented here, since the future cannot be anticipated with certainty. In order to illustrate the magnitude of the sensitivity of the long-range projections, six of the key assumptions were varied individually to determine the impact on the HI

actuarial present values and net cashflows.[5] The assumptions varied are the fertility rate, net immigration, real-wage differential, CPI, real-interest rate, and health care cost factors.[6]

For this analysis, the intermediate economic and demographic assumptions in the ***2001 Annual Report of the Board of Trustees of the Federal Hospital Insurance Trust Fund*** are used as the reference point. Each selected assumption is varied individually to produce three scenarios. All present values are calculated as of January 1, 2001 and are based on estimates of income and expenditures during the 75-year projection period.

Charts 7 through 12 show the net annual HI cashflow in nominal dollars and the present value of this net cashflow for each assumption varied. In most instances, the charts depicting the estimated net cashflow indicate that, after increasing in the early years, net cashflow decreases steadily through 2030 under all three scenarios displayed. On the present value charts, the same pattern is evident, though the magnitudes are lower because of the discounting process used for computing present values.

## Fertility Rate

Table 3 shows the net present value of cashflow during the 75-year projection period under three alternative ultimate fertility rate assumptions: 1.7, 1.95, and 2.2 children per woman.

**Table 3**
**Present Value of Estimated HI Income Less Expenditures under Various Fertility Rate Assumptions**

| Ultimate fertility rate[1] | 1.7 | 1.95 | 2.2 |
|---|---|---|---|
| Income minus expenditures *(in billions)* | -$4,878 | -$4,730 | -$4,569 |

[1] The total fertility rate for any year is the average number of children who would be born to a woman in her lifetime if she were to experience the birth rates by age observed in, or assumed for, the selected year, and if she were to survive the entire childbearing period.

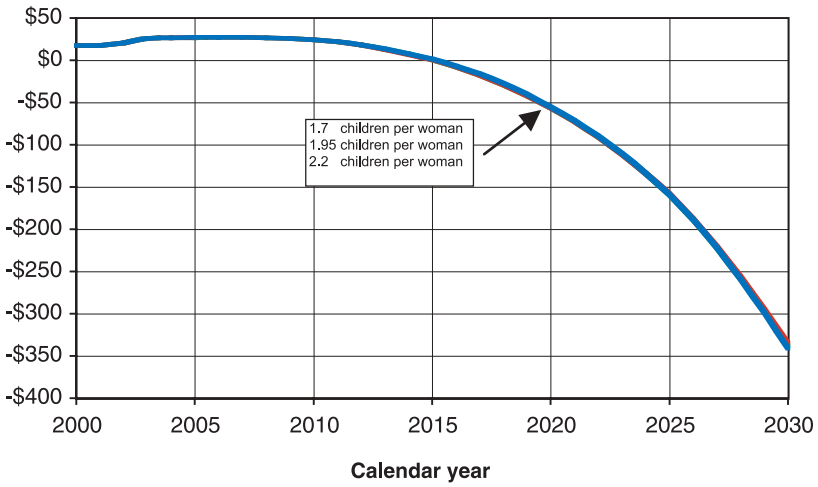
Table 3 demonstrates that if the assumed ultimate fertility rate is decreased from 1.95 to 1.7, the projected deficit of income over expenditures increases from $4,730 billion to $4,878 billion. On the other hand, if the ultimate fertility rate is increased from 1.95 to 2.2 children per woman, the deficit decreases to $4,569 billion.

Charts 7 and 7A show projections of the net cashflow under the three alternative fertility rate assumptions presented in table 3.

[5] Sensitivity analysis is not done for the SMI program due to its financing mechanism. Any change in assumptions would have no impact on the net cashflow since the change would affect income and expenditures equally.

[6] The sensitivity of the projected HI net cash flow to variations in future mortality rates is also of interest. At this time, however, relatively little is known about the relationship between improvements in life expectancy and the associated changes in health status and per-beneficiary health expenditures. As a result, it is not possible at present to prepare meaningful estimates of the HI mortality sensitivity. The Centers for Medicare & Medicaid Services is sponsoring a current research effort by the Rand Corporation that is expected to provide the information necessary to produce such estimates.

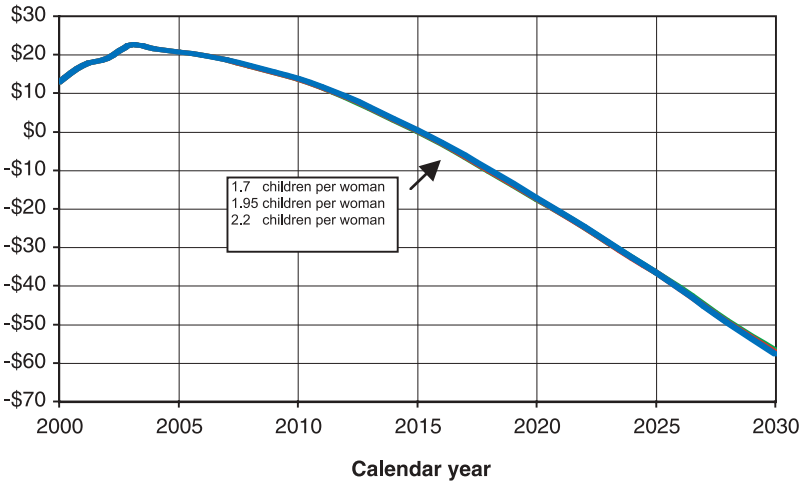
**Chart 7—HI Net Cashflow with Various Ultimate Fertility Rate Assumptions 2000 - 2030**
(In billions)




Source: CMS/OAct

As charts 7 and 7A indicate, the fertility rate assumption has only a negligible impact on projected HI cashflows over the next 30 years. This is because higher fertility in the first year does not affect the labor force until roughly 20 years have passed (increasing HI payroll taxes slightly) and has virtually no impact on the number of beneficiaries within this period. Over the full 75-year period, the changes are somewhat greater, as illustrated by the present values in table 3.

**Chart 7A—Present Value of HI Net Cashflow with Various Ultimate Fertility Rate Assumptions 2000 - 2030**
(In billions)




Source: CMS/OAct

## Net Immigration

Table 4 shows the net present value of cashflow during the 75-year projection period under three alternative net immigration assumptions: 655,000 persons, 900,000 persons, and 1,210,000 persons per year.

**Table 4**
**Present Value of Estimated HI Income Less Expenditures under Various Net Immigration Assumptions**

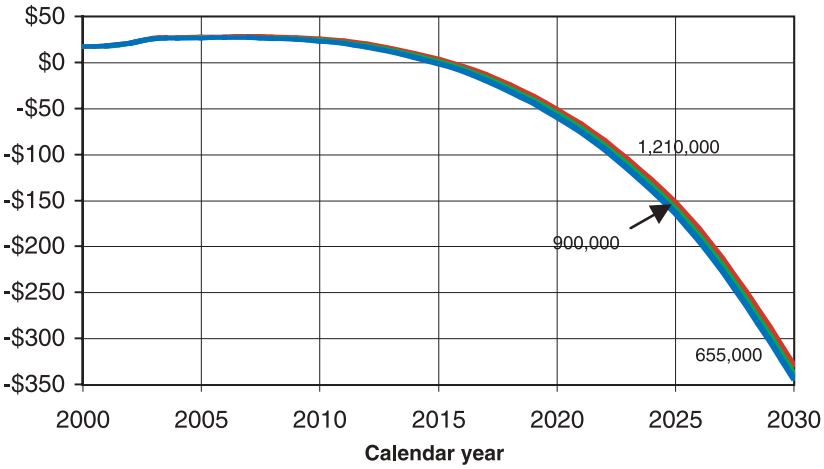
| | | | |
|---|---|---|---|
| Ultimate net immigration | 655,000 | 900,000 | 1,210,000 |
| Income minus expenditures *(in billions)* | -$4,679 | -$4,730 | -$4,775 |

Table 4 demonstrates that if the ultimate net immigration assumption is decreased from 900,000 to 655,000 persons, the deficit of income over expenditures decreases from $4,730 billion to $4,679 billion. On the other hand, if the ultimate net immigration assumption is increased from 900,000 to 1,210,000 persons, the deficit increases to $4,775 billion.

Charts 8 and 8A show projections of the net cashflow under the three alternative net immigration assumptions presented in table 4.

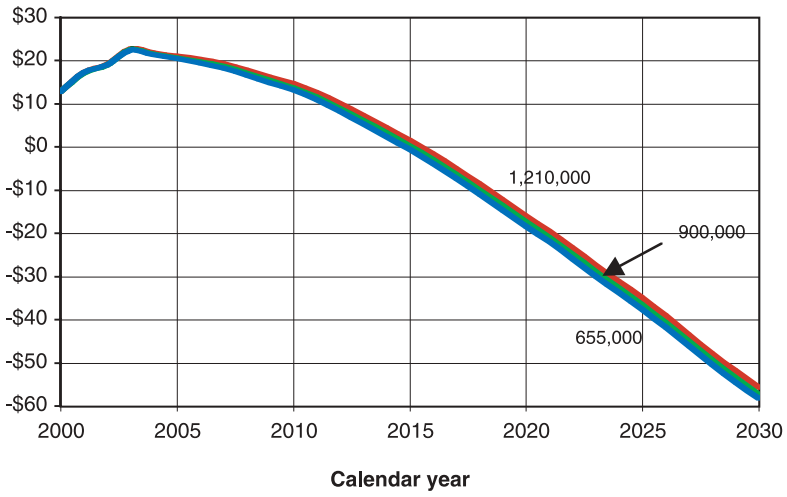
As charts 8 and 8A indicate, this assumption has an impact on projected HI cashflow starting almost immediately. Because immigration tends to occur among younger individuals, the number of covered workers is affected immediately, while the number of beneficiaries is affected much less quickly. Nonetheless, variations in net immigration result in fairly small differences in cashflow.

**Chart 8—HI Net Cashflow with Various Net Immigration Assumptions 2000 - 2030**
(In billions)




Source: CMS/OAct

**Chart 8A—Present Value of HI Net Cashflow with Various Net Immigration Assumptions 2000 - 2030**
(In billions)




Source: CMS/OAct

## Real-Wage Differential

Table 5 shows the net present value of cashflow during the 75-year projection period under three alternative ultimate real-wage differential assumptions: 0.5, 1.0, and 1.5 percentage points. In each case, the CPI is assumed to be 3.3 percent, yielding ultimate percentage increases in average annual wages in covered employment of 3.8, 4.3, and 4.8 percent, respectively.

**Table 5**
**Present Value of Estimated HI Income Less Expenditures under Various Real-Wage Assumptions**

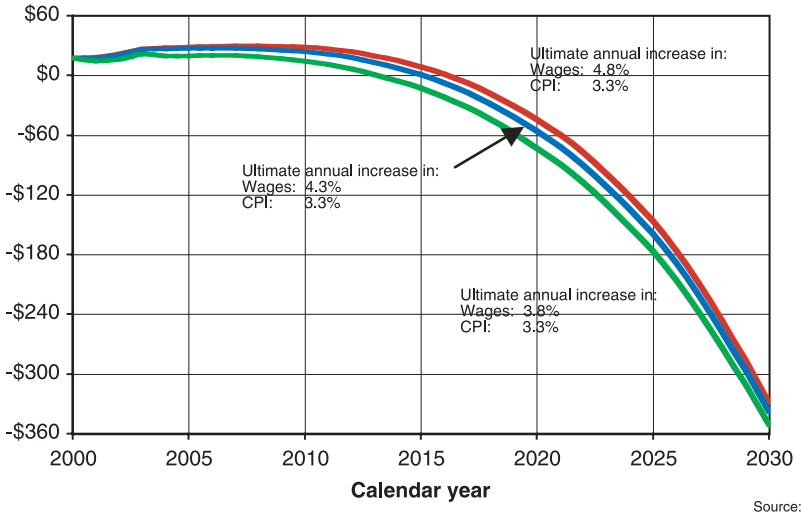
| | | | |
|---|---|---|---|
| Ultimate percentage increase in wages - CPI | 3.8 - 3.3 | 4.3 - 3.3 | 4.8 - 3.3 |
| Ultimate percentage increase in real-wage differential | 0.5 | 1.0 | 1.5 |
| Income minus expenditures *(in billions)* | -$4,988 | -$4,730 | -$4,539 |

Table 5 demonstrates that if the ultimate real-wage differential assumption is decreased from 1.0 percentage point to 0.5 percentage point, the deficit of income over expenditures increases from $4,730 billion to $4,988 billion. On the other hand, if the ultimate real-wage differential assumption is increased from 1.0 percentage point to 1.5 percentage points, the deficit decreases to $4,539 billion.

Charts 9 and 9A show projections of the net cashflow under the three alternative real-wage differential assumptions presented in table 5.

As charts 9 and 9A indicate, this assumption has a fairly large impact on projected HI cashflow very early in the projection period. Higher real-wage differential

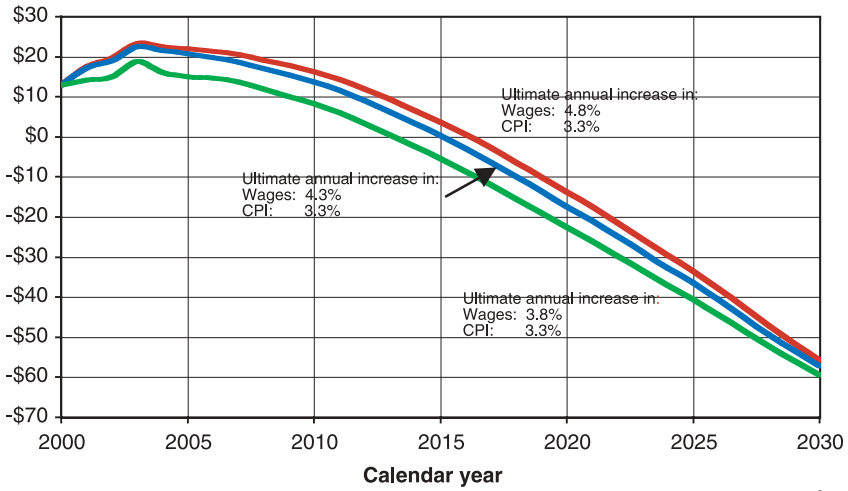
**Chart 9—HI Net Cashflow with Various Real-Wage Assumptions 2000 - 2030**
(In billions)




Source: CMS/OAct

assumptions immediately increase both HI expenditures for health care and wages for all workers. Though there is a full effect on wages and payroll taxes, the effect on benefits is only partial, since not all health care costs are wage-related.

**Chart 9A—Present Value of HI Net Cashflow with Various Real-Wage Assumptions 2000 - 2030**
(In billions)




Source: CMS/OAct

## Consumer Price Index

Table 6 shows the net present value of cashflow during the 75-year projection period under three alternative ultimate CPI rate-of-increase assumptions: 2.3, 3.3, and 4.3 percent. In each case, the ultimate real-wage differential is assumed to be 1.0 percent,

yielding ultimate percentage increases in average annual wages in covered employment of 3.3, 4.3, and 5.3 percent, respectively.

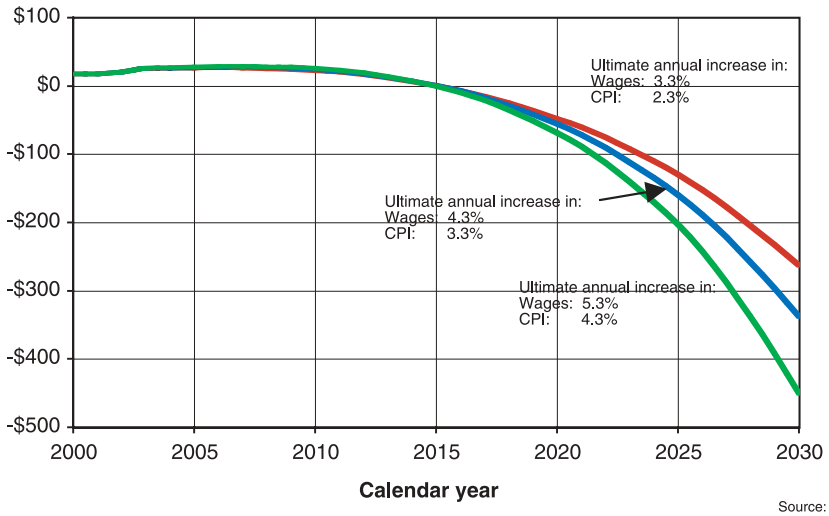
**Table 6**
**Present Value of Estimated HI Income Less Expenditures under Various CPI-Increase Assumptions**

| | | | |
|---|---|---|---|
| Ultimate percentage increase in wages - CPI | 3.3 - 2.3 | 4.3 - 3.3 | 5.3 - 4.3 |
| Income minus expenditures *(in billions)* | -$4,748 | -$4,730 | -$4,731 |

Table 6 demonstrates that if the ultimate CPI increase assumption is decreased from 3.3 percent to 2.3 percent, the deficit of income over expenditures increases from $4,730 billion to $4,748 billion. Furthermore, if the ultimate CPI increase assumption is increased from 3.3 percent to 4.3 percent, the deficit increases to $4,731 billion.

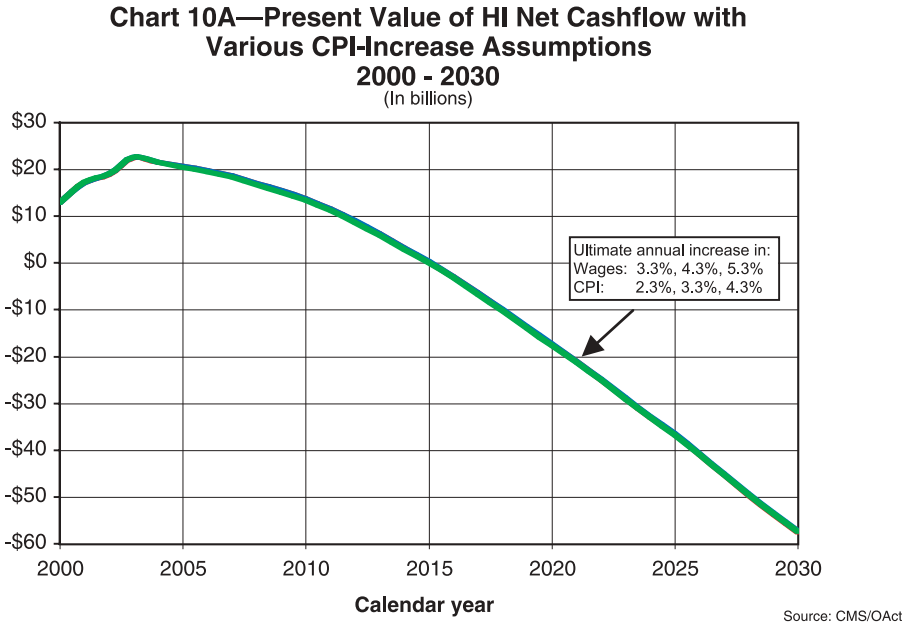
Charts 10 and 10A show projections of the net cashflow under the three alternative CPI rate-of-increase assumptions presented in table 6.

**Chart 10—HI Net Cashflow with Various CPI-Increase Assumptions 2000 - 2030**
(In billions)




Source: CMS/OAct

As charts 10 and 10A indicate, this assumption has a large impact on projected HI cashflow in nominal dollars but only a negligible impact when the cashflow is expressed as present values. The relative insensitivity of the projected present values of HI cashflow to different levels of general inflation occurs because inflation tends to affect both income and costs equally. In nominal dollars, however, a given deficit "looks bigger" under high-inflation conditions but is not significantly different when it is expressed as a present value or relative to taxable payroll. This sensitivity test serves as a useful example of the limitations of nominal-dollar projections over long periods.




## Real-Interest Rate

Table 7 shows the net present value of cashflow during the 75-year projection period under three alternative ultimate real-interest assumptions: 2.2, 3.0, and 3.7 percent. In each case, the ultimate annual increase in the CPI is assumed to be 3.3 percent, resulting in ultimate annual yields of 5.5, 6.3, and 7.0 percent, respectively.

**Table 7**
**Present Value of Estimated HI Income Less Expenditures under Various Real-Interest Assumptions**

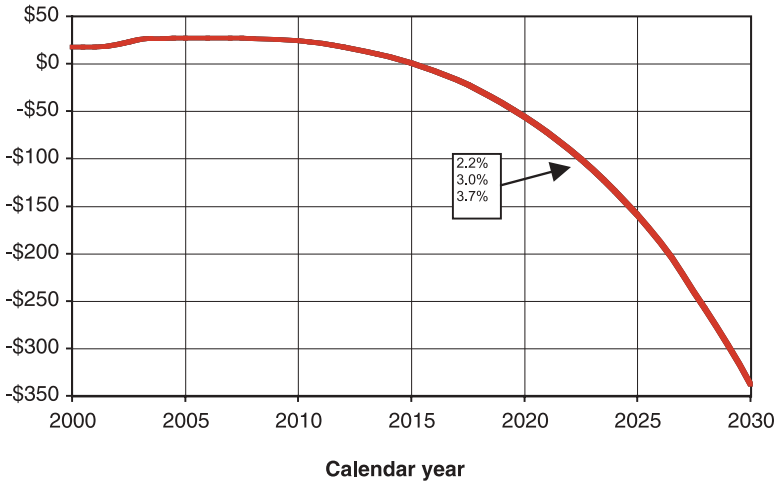
| | | | |
|---|---|---|---|
| Ultimate real-interest rate | 2.2 % | 3.0 % | 3.7 % |
| Income minus expenditures *(in billions)* | -$7,003 | -$4,730 | -$3,372 |

Table 7 demonstrates that if the ultimate real-interest rate percentage is decreased from 3.0 percent to 2.2 percent, the deficit of income over expenditures increases from $4,730 billion to $7,003 billion. On the other hand, if the ultimate real-interest rate assumption is increased from 3.0 percent to 3.7 percent, the deficit decreases to $3,372 billion.

Charts 11 and 11A show projections of the net cashflow under the three alternative real-interest assumptions presented in table 7.

As shown in charts 11 and 11A, the present values of the net cashflow are more sensitive to the interest assumption than is the nominal net cashflow. This is not an indication of the actual role that interest plays in the financing of the HI program. In actuality, interest finances very little of the cost of the HI program because, under the

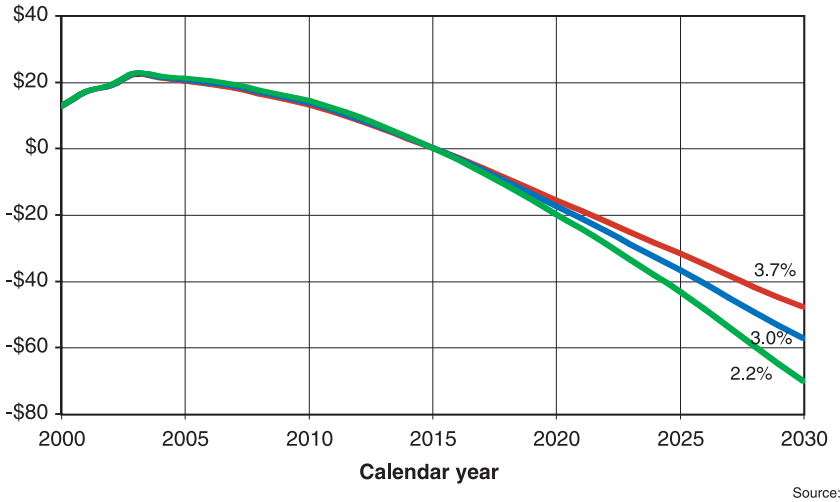
**Chart 11—HI Net Cashflow with Various Real-Interest Rate Assumptions 2000 - 2030**
(In billions)




Source: CMS/OAct

intermediate assumptions, the fund is projected to be relatively low and exhausted by 2029. These results illustrate the substantial sensitivity of present value measures to different interest rate assumptions. With higher assumed interest, the very large deficits in the more distant future are discounted more heavily (that is, are given less weight), and the overall net present value is smaller.

**Chart 11A—Present Value of HI Net Cashflow with Various Real-Interest Rate Assumptions 2000 - 2030**
(In billions)




Source: CMS/OAct

## Health Care Cost Factors

Table 8 shows the net present value of cashflow during the 75-year projection period under three alternative assumptions of the annual growth rate in the aggregate cost of providing covered health care services to beneficiaries. These assumptions are that the ultimate annual growth rate in such costs, relative to taxable payroll, will be 1 percent slower than the intermediate assumptions, the same as the intermediate assumptions, and 1 percent faster than the intermediate assumptions. In each case, the taxable payroll will be the same as that which was assumed for the intermediate assumptions.

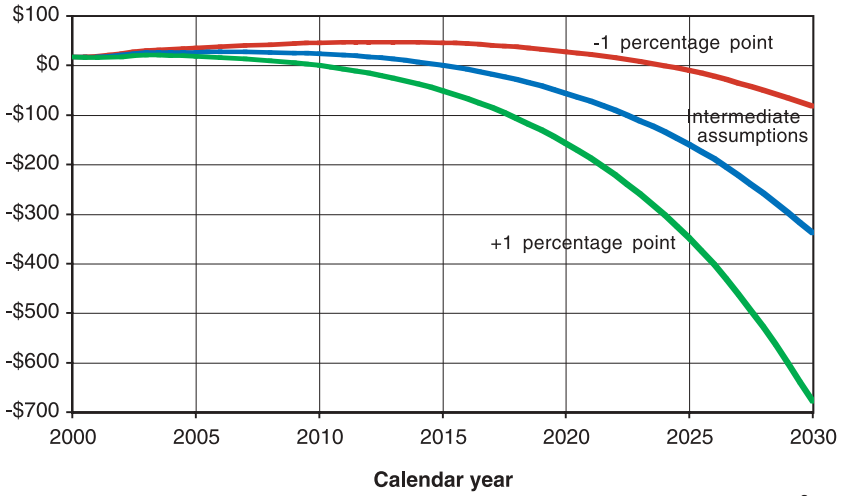
**Table 8**
**Present Value of Estimated HI Income Less Expenditures under Various Health Care Cost Growth Rate Assumptions**

| Annual cost/payroll relative growth rate | -1 percentage point | Intermediate assumptions | + 1 percentage point |
|---|---|---|---|
| Income minus expenditures *(in billions)* | -$811 | -$4,730 | -$11,155 |

Table 8 demonstrates that if the ultimate growth rate assumption is 1 percentage point lower than the intermediate assumptions, the deficit of income over expenditures decreases from $4,730 billion to $811 billion. On the other hand, if the ultimate growth rate assumption is 1 percentage point higher than the intermediate assumptions, the deficit increases substantially to $11,155 billion.

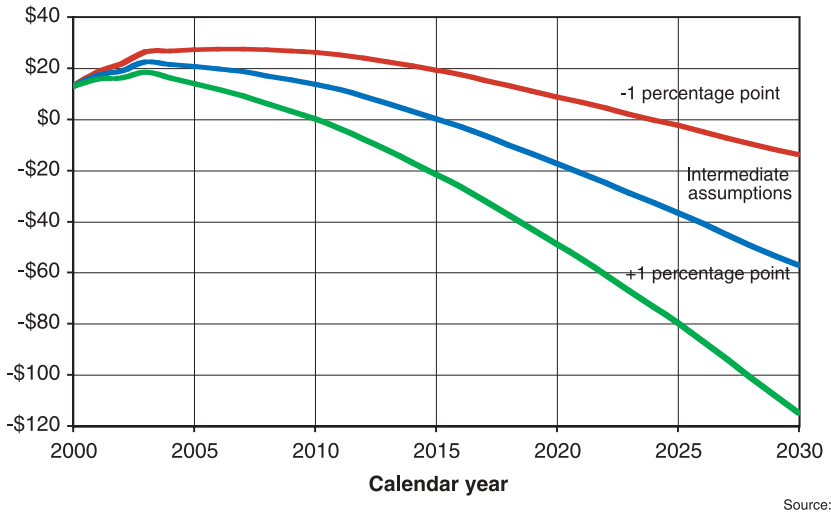
Charts 12 and 12A show projections of the net cashflow under the three alternative annual growth rate assumptions presented in table 8.

**Chart 12—HI Net Cashflow with Various Health Care Cost Factor Assumptions 2000 - 2030**
(In billions)




Source: CMS/OAct

**Chart 12A—Present Value of HI Net Cashflow with Various Health Care Cost Factors 2000 - 2030**
(In billions)




Source: CMS/OAct

This assumption has a dramatic impact on projected HI cashflow. The assumptions analyzed thus far have affected HI income and costs simultaneously. However, several factors, such as the utilization of services by beneficiaries or the relative complexity of services provided, can affect costs without affecting tax income. As charts 12 and 12A indicate, the financial status of the HI program is extremely sensitive to the relative growth rates for health care service costs versus taxable payroll.

# PROGRAM FINANCES AND SUSTAINABILITY

## HI

The HI program is substantially out of financial balance in the long range. Under the Medicare Trustees' intermediate assumptions, income is projected to continue to moderately exceed expenditures for the next 20 years but to fall short by steadily increasing amounts in 2021 and later. These shortfalls can be met by redeeming trust fund assets, but only until 2029.

To bring the HI program into actuarial balance over the next 75 years under the intermediate assumptions, either outlays would have to be reduced by 37 percent or income increased by 60 percent (or some combination of the two) throughout the 75-year period. These substantial changes in income and/or outlays are needed, in part as a result of the impending retirement of the baby boom generation.

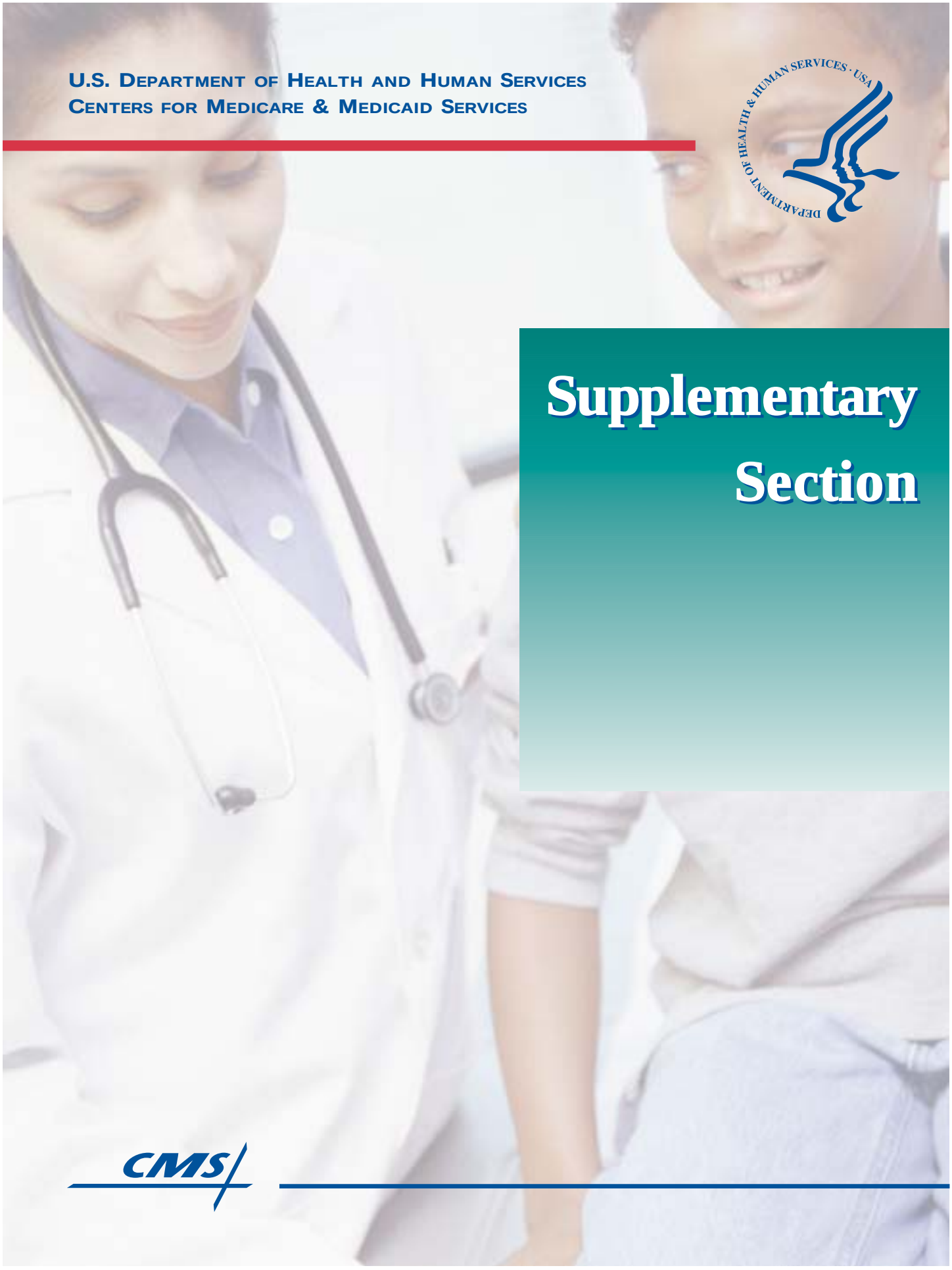
The projections shown in this section indicate that without additional legislation, the fund would be exhausted in the future—initially producing payment delays, but very quickly leading to a curtailment of health care services to beneficiaries. In their 2001 annual report to Congress, the Medicare Board of Trustees urges the nation's policy makers to address the remaining financial imbalance facing the HI trust fund by taking "effective and decisive action...to build upon the strong steps taken in recent reforms." They also state that "Consideration of further reforms should occur in the relatively near future."

## SMI

The financing established for the SMI program for calendar year 2001 is estimated to be sufficient to cover program expenditures for that year and to preserve an adequate contingency reserve in the SMI trust fund. Moreover, for all future years, trust fund income is projected to equal expenditures—but only because beneficiary premiums and government general revenue contributions are set to meet expected costs each year.

The SMI program's automatic financing provisions prevent crises such as those faced in recent years by the HI trust fund, where assets were projected to be exhausted in the near future. As a result, there has been substantially less attention directed toward the financial status of the SMI program than to the HI program—even though SMI expenditures have increased faster than HI expenditures in most years and are expected to continue to do so for a number of years in the future.

SMI program costs have generally grown faster than the GDP, and this trend is expected to continue under present law. The projected increases are initially attributable in part to assumed continuing growth in the volume and intensity of services provided per beneficiary. Starting in 2010, the retirement of the post-World War II baby boom generation will also have a major influence on the growth in program costs. This growth in SMI expenditures relative to GDP is a matter of great concern. In their 2001 annual report to Congress, the Medicare Board of Trustees emphasizes the seriousness of these concerns and urges the nation's policy makers "to consider effective means of controlling SMI costs in the near term."



U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services

# Supplementary Section

CMS

## CONSOLIDATING BALANCE SHEET
## As of September 30, 2001
(in millions)

| | MEDICARE | | | HEALTH | | | Combined | Intra-CMS | Consolidated |
|---|---|---|---|---|---|---|---|---|---|
| | HI | SMI | Total | Medicaid | SCHIP | Others | Totals | Eliminations | Totals |
| **ASSETS** | | | | | | | | | |
| **Intragovernmental Assets:** | | | | | | | | | |
| Fund Balance with Treasury | $293 | $(69) | $224 | $5,462 | $11,501 | $240 | $17,427 | | $17,427 |
| Trust Fund Investments | 200,409 | 42,683 | 243,092 | | | | 243,092 | | 243,092 |
| Accounts Receivable, Net | 3,184 | 1,592 | 4,776 | 26 | | | 4,802 | $(4,248) | 554 |
| Other Assets | | | | | | | | | |
| Anticipated Congressional Appropriation | 2,630 | 1,592 | 4,222 | 6,944 | | | 11,166 | | 11,166 |
| **Total Intragovernmental Assets** | **$206,516** | **$45,798** | **$252,314** | **$12,432** | **$11,501** | **$240** | **$276,487** | **$(4,248)** | **$272,239** |
| Accounts Receivable, Net | 2,128 | 966 | 3,094 | 949 | | 43 | 4,086 | | 4,086 |
| Cash & Other Monetary Assets | 31 | 106 | 137 | | | | 137 | | 137 |
| Property, Plant & Equipment, Net | 2 | 10 | 12 | | | | 12 | | 12 |
| **TOTAL ASSETS** | **$208,677** | **$46,880** | **$255,557** | **$13,381** | **$11,501** | **$283** | **$280,722** | **$(4,248)** | **$276,474** |

| | MEDICARE | | | HEALTH | | | Combined | Intra-CMS | Consolidated |
|---|---|---|---|---|---|---|---|---|---|
| | HI | SMI | Total | Medicaid | SCHIP | Others | Totals | Eliminations | Totals |
| **LIABILITIES** | | | | | | | | | |
| **Intragovernmental Liabilities:** | | | | | | | | | |
| Accounts Payable | | | | | $26 | | $26 | $(26) | |
| Accrued Payroll and Benefits | $1 | $3 | $4 | | | | 4 | | $4 |
| Other Intragovernmental Liabilities | 3,142 | 1,717 | 4,859 | $1 | | $60 | 4,920 | (4,222) | 698 |
| **Total Intragovernmental Liabilities** | **$3,143** | **$1,720** | **$4,863** | **$1** | **$26** | **$60** | **$4,950** | **(4,248)** | **$702** |
| Entitlement Benefits Due & Payable | 13,617 | 13,464 | 27,081 | 13,360 | | | 40,441 | | 40,441 |
| Federal Employee & Veterans' Benefits | 3 | 6 | 9 | 1 | | | 10 | | 10 |
| Accrued Payroll & Benefits | 19 | 33 | 52 | 3 | | | 55 | | 55 |
| Other Liabilities | 55 | 141 | 196 | | | 14 | 210 | | 210 |
| **TOTAL LIABILITIES** | **$16,837** | **$15,364** | **$32,201** | **$13,365** | **$26** | **$74** | **$45,666** | **$(4,248)** | **$41,418** |
| **NET POSITION** | | | | | | | | | |
| Unexpended Appropriations | 3 | | 3 | | 11,475 | 86 | 11,564 | | 11,564 |
| Cumulative Results of Operations | 191,837 | 31,516 | 223,353 | 16 | | 123 | 223,492 | | 223,492 |
| **TOTAL NET POSITION** | **$191,840** | **$31,516** | **$223,356** | **$16** | **$11,475** | **$209** | **$235,056** | | **$235,056** |
| **TOTAL LIABILITIES & NET POSITION** | **$208,677** | **$46,880** | **$255,557** | **$13,381** | **$11,501** | **$283** | **$280,722** | **$(4,248)** | **$276,474** |

## CONSOLIDATING STATEMENT OF NET COST
## Year Ended September 30, 2001

(in millions)

| | MEDICARE | | | HEALTH | | | Combined | Intra-CMS | Consolidated |
|---|---|---|---|---|---|---|---|---|---|
| | HI | SMI | Total | Medicaid | SCHIP | Others | Totals | Eliminations | Totals |
| **NET PROGRAM/ACTIVITY COSTS** | | | | | | | | | |
| **GPRA Programs** | | | | | | | | | |
| Medicare *(includes estimated improper payments of $7.2-$16.9 billion)* | $140,832 | $78,525 | $219,357 | | | | $219,357 | | $219,357 |
| Medicaid | | | | $129,211 | | | 129,211 | $1,239 | 130,450 |
| SCHIP | | | | | $3,726 | | 3,726 | (1,239) | 2,487 |
| **NET COST—GPRA PROGRAMS** | **$140,832** | **$78,525** | **$219,357** | **$129,211** | **$3,726** | | **$352,294** | | **$352,294** |
| **Other Activities** | | | | | | | | | |
| CLIA | | | | | | 83 | 83 | | 83 |
| Ticket to Work Incentive | | | | | | 2 | 2 | | 2 |
| Other | | | | | | 2 | 2 | | 2 |
| **NET COST—OTHER ACTIVITIES** | | | | | | **$87** | **$87** | | **$87** |
| **NET COST OF OPERATIONS** | **$140,832** | **$78,525** | **$219,357** | **$129,211** | **$3,726** | **$87** | **$352,381** | | **$352,381** |

## CONSOLIDATING STATEMENT OF CHANGES IN NET POSITION
## Year Ended September 30, 2001

(in millions)

| | MEDICARE | | | HEALTH | | | Combined | Intra-CMS | Consolidated |
|---|---|---|---|---|---|---|---|---|---|
| | HI | SMI | Total | Medicaid | SCHIP | Others | Totals | Eliminations | Totals |
| **NET COST OF OPERATIONS** | **$140,832** | **$78,525** | **$219,357** | **$129,211** | **$3,726** | **$87** | **$352,381** | | **$352,381** |
| **Financing Sources** | | | | | | | | | |
| *(other than exchange revenues)* | | | | | | | | | |
| Appropriations Used | $8,223 | $71,430 | $79,653 | $128,944 | $3,725 | $3 | $212,325 | | $212,325 |
| Taxes *(and other non-exchange revenue)* | 163,519 | 3,139 | 166,658 | | | | 166,658 | | 166,658 |
| Imputed Financing | 8 | 16 | 24 | 3 | | | 27 | | 27 |
| Transfers-In | | | | | | | | | |
| Non-Expenditure Transfers-Benefit Payments | 141,293 | 96,447 | 237,740 | | | | 237,740 | $(237,740) | |
| Trust Fund Draws | 691 | 1,326 | 2,017 | 224 | 1 | 23 | 2,265 | (2,265) | |
| Federal Matching Contribution | | 71,430 | 71,430 | | | | 71,430 | (71,430) | |
| Other | 8,719 | 1 | 8,720 | 60 | | | 8,780 | (8,283) | 497 |
| Transfers-Out | | | | | | | | | |
| Non-Expenditure Transfers-Benefit Payments | (141,293) | (96,447) | (237,740) | | | | (237,740) | 237,740 | |
| Expenditure Transfers to Program Management | (840) | (1,425) | (2,265) | | | | (2,265) | 2,265 | |
| Payments to Health Care Trust Funds | (8,223) | (71,430) | (79,653) | | | | (79,653) | 79,653 | |
| Other | (1,739) | (560) | (2,299) | | | | (2,299) | 60 | (2,239) |
| Other Revenues & Financing Sources | | | | | | | | | |
| Reclassification of Equity Accounts | (3) | (3) | (6) | (1) | | | (7) | | (7) |
| **TOTAL FINANCING SOURCES** | **$170,355** | **$73,924** | **$244,279** | **$129,230** | **$3,726** | **$26** | **$377,261** | | **$377,261** |
| **NET RESULTS OF OPERATIONS** | **29,523** | **(4,601)** | **24,922** | **19** | | **(61)** | **24,880** | | **24,880** |
| **NET CHANGE IN CUMULATIVE RESULTS OF OPERATIONS** | **29,523** | **(4,601)** | **24,922** | **19** | | **(61)** | **24,880** | | **24,880** |
| Increase (Decrease) in Unexpended Appropriations | (10) | (3,129) | (3,139) | | 524 | 60 | (2,555) | | (2,555) |
| **CHANGE IN NET POSITION** | **29,513** | **(7,730)** | **21,783** | **19** | **524** | **(1)** | **22,325** | | **22,325** |
| Net Position—Beginning of Period | 162,327 | 39,246 | 201,573 | (3) | 10,951 | 210 | 212,731 | | 212,731 |
| **NET POSITION—END OF PERIOD** | **$191,840** | **$31,516** | **$223,356** | **$16** | **$11,475** | **$209** | **$235,056** | | **$235,056** |

## COMBINING STATEMENT OF BUDGETARY RESOURCES
## Year Ended September 30, 2001

(in millions)

| | HI | SMI | HCFAC | Payments to Trust Funds | Program Mgmt. | Medicaid | SCHIP | TWI | HMO Loan | Combined Totals |
|---|---|---|---|---|---|---|---|---|---|---|
| **Budgetary Resources:** | | | | | | | | | | |
| Budget Authority | $171,436 | $95,679 | $950 | $75,373 | | $129,880 | $4,249 | $62 | | $477,629 |
| Unobligated Balances—Beginning of Period | | | 30 | 3,142 | $199 | 110 | | | $10 | 3,491 |
| Spending Authority from Offsetting Collections | 1 | | 3 | | 2,264 | 1,298 | | | | 3,566 |
| Adjustments | (29,688) | 3,750 | 16 | (3,081) | 115 | 1,949 | 3,427 | | | (23,512) |
| **TOTAL BUDGETARY RESOURCES** | **$141,749** | **$99,429** | **$999** | **$75,434** | **$2,578** | **$133,237** | **$7,676** | **$62** | **$10** | **$461,174** |
| **Status of Budgetary Resources:** | | | | | | | | | | |
| Obligations Incurred | $141,749 | $99,429 | $958 | $75,431 | $2,384 | $133,127 | $7,676 | 22 | | $460,776 |
| Unobligated Balances—Available | | | 3 | 3 | 30 | 110 | | 40 | | 186 |
| Unobligated Balances—Not Available | | | 38 | | 164 | | | | 10 | 212 |
| **TOTAL STATUS OF BUDGETARY RESOURCES** | **$141,749** | **$99,429** | **$999** | **$75,434** | **$2,578** | **$133,237** | **$7,676** | **$62** | **$10** | **$461,174** |
| **Outlays:** | | | | | | | | | | |
| Obligations Incurred | 141,749 | 99,429 | 958 | 75,431 | 2,384 | 133,127 | 7,676 | 22 | | 460,776 |
| Less: Spending Authority from Offsetting Collections and Adjustments | (1) | | (19) | | (2,384) | (4,565) | (3,427) | | (1) | (10,397) |
| Obligated Balance, Net—Beginning of Period | 635 | 167 | 172 | | 53 | 5,581 | 10,951 | | | 17,559 |
| Less: Obligated Balance, Net—End of Period | (408) | (144) | (185) | | (176) | (5,332) | (11,501) | (20) | | (17,766) |
| **TOTAL OUTLAYS** | **$141,975** | **$99,452** | **$926** | **$75,431** | **$(123)** | **$128,811** | **$3,699** | **$2** | **$(1)** | **$450,172** |

## GROSS COST AND EXCHANGE REVENUE
## Year Ended September 30, 2001

(in millions)

| | INTRAGOVERNMENTAL | | | | | | WITH THE PUBLIC | | |
|---|---|---|---|---|---|---|---|---|---|
| | Gross Cost | | | Less: Exchange Revenue | | | Gross Cost | Less: Exchange Revenue | Net Cost of Operations |
| | Combined | Eliminations | Consolidated | Combined | Eliminations | Consolidated | | | |
| **NET PROGRAM/ACTIVITY COSTS** | | | | | | | | | |
| **GPRA Programs** | | | | | | | | | |
| Medicare | | | | | | | | | |
| HI | $176 | | $176 | $1 | | $1 | $142,099 | $1,442 | $140,832 |
| SMI | 130 | | 130 | | | | 100,702 | 22,307 | 78,525 |
| Medicaid | 14 | | 14 | 1,239 | $(1,239) | | 130,436 | | 130,450 |
| SCHIP | 1,248 | $(1,239) | 9 | | | | 2,478 | | 2,487 |
| **SUBTOTAL** | **$1,568** | **$(1,239)** | **$329** | **$1,240** | **$(1,239)** | **$1** | **$375,715** | **$23,749** | **$352,294** |
| **Other Activities** | | | | | | | | | |
| CLIA | 18 | | 18 | | | | 125 | 60 | 83 |
| Ticket to Work Incentive | | | | | | | 2 | | 2 |
| Other | | | | 2 | | 2 | 4 | | 2 |
| **SUBTOTAL** | **$18** | | **$18** | **$2** | | **$2** | **$131** | **$60** | **$87** |
| **PROGRAM/ACTIVITY TOTALS** | **$1,586** | **$(1,239)** | **$347** | **$1,242** | **$(1,239)** | **$3** | **$375,846** | **$23,809** | **$352,381** |

## CONSOLIDATED INTRAGOVERNMENTAL BALANCES
## Year Ended September 30, 2001

(in millions)

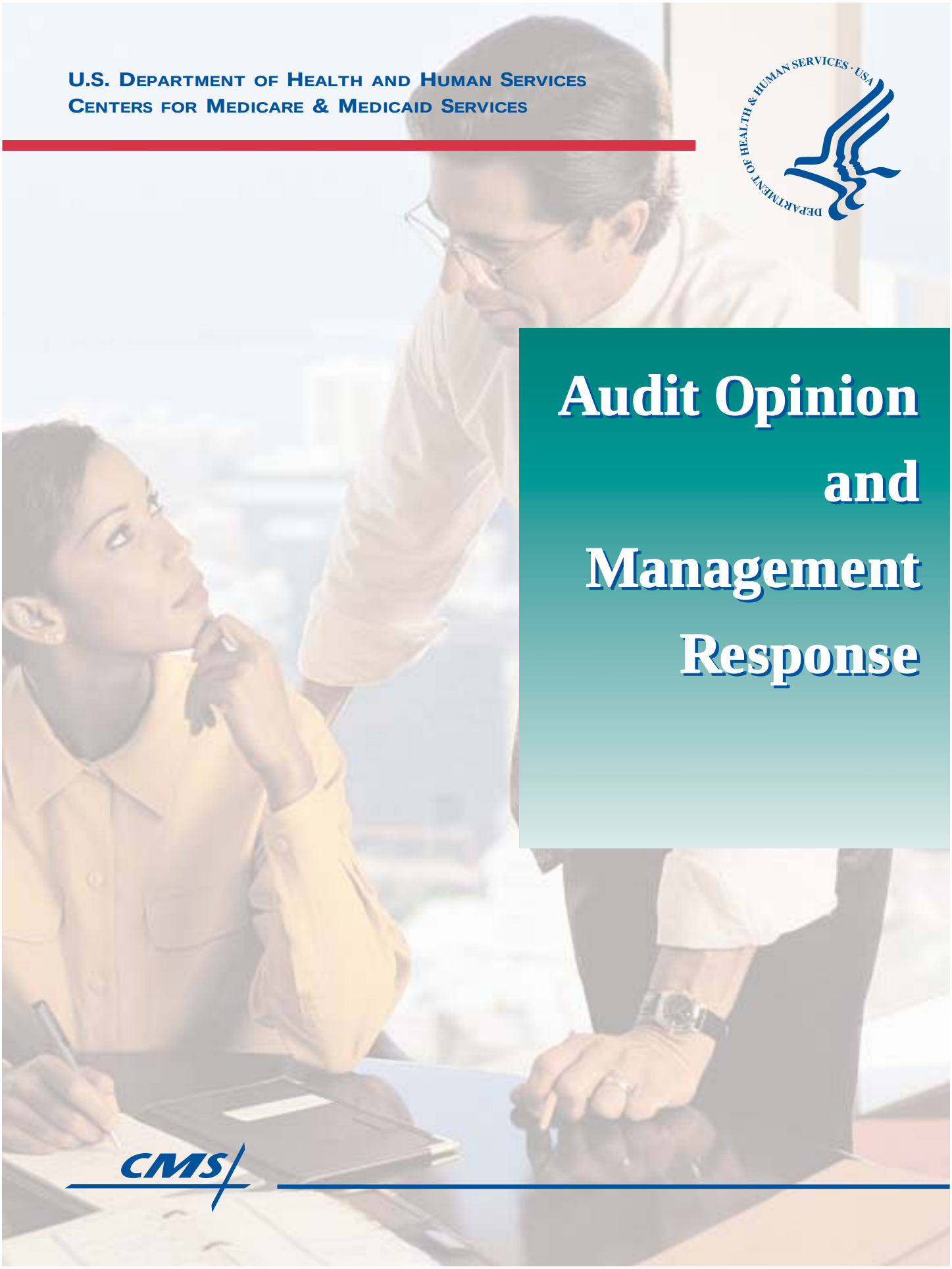
| | *TFM Dept. Code | Fund Bal. with Treasury | Investments | Accounts Receivable | Other |
|---|---|---|---|---|---|
| **INTRAGOVERNMENTAL ASSETS** | | | | | |
| **Agency** | | | | | |
| Department of the Treasury | 20 | $17,427 | $243,092 | | $11,166 |
| Department of Defense | 17, 21 57, 97 | | | 123 | |
| All Other Federal Agencies | | | | 431 | |
| | | **$17,427** | **$243,092** | **$554** | **$11,166** |

| | *TFM Dept. Code | Accounts Payable | Environmental & Disposal Costs | Accrued Payroll & Benefits | Other |
|---|---|---|---|---|---|
| **INTRAGOVERNMENTAL LIABILITIES** | | | | | |
| **Agency** | | | | | |
| Department of Labor | 16 | | | $2 | |
| Department of the Treasury | 20 | | | | $666 |
| Office of Personnel Management | 24 | | | 2 | |
| General Services Administration | 47 | | | | 16 |
| All Other Federal Agencies | | | | | 16 |
| | | | | **$4** | **$698** |

| | *TFM Dept. Code | Earned Revenue | Gross Cost | Non-exchange Revenue Transfers-in | Non-exchange Revenue Transfers-out |
|---|---|---|---|---|---|
| **INTRAGOVERNMENTAL REVENUES & EXPENSES** | | | | | |
| **Agency** | | | | | |
| Department of Commerce | 13 | | $3 | | |
| Department of Justice | 15 | $1 | 88 | | |
| Department of Labor | 16 | | 1 | | |
| Department of the Treasury | 20 | | | | $(1,177) |
| Department of Defense | 17, 21 57, 97 | | 76 | $62 | |
| Office of Personnel Management | 24 | | 71 | | |
| Social Security Administration | 28 | | | 2 | (1,045) |
| General Services Administration | 47 | | 38 | | (8) |
| Department of Transportation | 69 | | | 2 | |
| Department of Health and Human Services | 75 | 2 | 52 | | (4) |
| All Other Federal Agencies | | | 18 | 431 | (5) |
| | | **$3** | **$347** | **$497** | **$(2,239)** |

* Treasury Financial Manual

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services



# Audit Opinion and Management Response

CMS

# Memorandum

Date FEB 13 2002

From Janet Rehnquist
Inspector General

Subject Report on the Financial Statement Audit of the Centers for Medicare and Medicaid Services for Fiscal Year 2001 (A-17-01-02001)

To Thomas Scully
Administrator
Centers for Medicare and Medicaid Services

The attached final report presents the results of the audit of the Fiscal Year (FY) 2001 financial statements of the Centers for Medicare and Medicaid Services (CMS). The firm Ernst & Young LLP (E&Y) undertook the audit in support of the Departmentwide financial statement audit by the Office of Inspector General (OIG) and in accordance with the Government Management Reform Act of 1994. The OIG exercised technical oversight and quality control over the audit.

The audit objectives were to determine whether (1) the CMS consolidating balance sheets as of September 30, 2001 and 2000, and the related consolidating statements of net costs for the FYs then ended, as well as the consolidating statement of changes in net position, consolidated statements of financing, and combined statements of budgetary resources for the FY ended September 30, 2001, were fairly presented in all material respects; (2) CMS internal controls provided reasonable assurance that transactions were properly recorded and accounted for to permit the preparation of reliable financial statements; and (3) CMS complied with laws and regulations that could have a direct and material effect on the financial statements.

In the auditor's opinion, the financial statements referred to above present fairly, in all material respects, the financial position of CMS as of September 30, 2001 and 2000, and its net costs for the years then ended, as well as the changes in net position, budgetary resources, and reconciliation of net costs to budgetary obligations for FY 2001 in conformity with accounting principles generally accepted in the United States.

The CMS is commended for sustaining the unqualified audit opinion first issued on the FY 1999 financial statements. While substantial progress has been made in providing reliable financial information, CMS continues to be impaired by the absence of a fully integrated financial management system to accumulate, analyze, and report financial information in a timely manner. As discussed in the auditor's report on internal controls, material weaknesses continue in financial systems and regional and central office oversight and in Medicare electronic data processing (EDP) controls.

**Financial Systems, Regional and Central Office Oversight (Partial Repeat Condition).** The Medicare contractors made improvements in maintaining supporting records for Medicare activities and yearend balances. However, because they lacked an integrated accounting system to accumulate and report financial information, they continued to use ad hoc, labor-intensive reports. This increased the risk of human error, material misstatement, or omission when reporting financial information. Also, independent verification controls were not established or were not consistently applied to provide reasonable assurance that amounts reported to CMS were valid, accurately summarized, and sufficiently documented. In addition, accounts receivable control deficiencies continued at the contractors.

As reported in FY 2000, CMS's oversight of Medicare contractor operations and financial management controls did not provide reasonable assurance that material errors would be detected and corrected in a timely manner. While the CMS central office continued to enhance its periodic analyses and oversight of information included in the financial statements, supervisory reviews of contractor reconciliations, reports, and development of financial statements were not consistently performed and documented. Also, the regional offices did not perform certain procedures to ensure that financial data provided by the contractors were reliable, accurate, and complete.

**Medicare Electronic Data Processing Controls (Repeat Condition).** The CMS relies on extensive EDP operations at both its central office and the Medicare contractors to administer the Medicare program and to process and account for Medicare expenditures. Internal controls over these operations are essential to ensure the integrity, confidentiality, and reliability of critical data while reducing the risk of errors, fraud, and other illegal acts. In FY 2001, numerous and continuing weaknesses at the Medicare contractors, as well as certain application control weaknesses at a contractor shared system, were prevalent. Such weaknesses increase the risk of (1) unauthorized access to and disclosure of sensitive information, (2) malicious changes that could interrupt data processing or destroy files, (3) improper Medicare payments, and (4) disruption of critical operations.

The CMS's comments on the draft of this report have been incorporated where appropriate. Officials in your office have concurred with the recommendations and are in the process of taking corrective action.

We would appreciate your views and information on the status of any action taken or contemplated on the recommendations within the next 60 days. If you have any questions, please call me or have your staff contact Joseph E. Vengrin, Assistant Inspector General for Audit Operations and Financial Statement Activities, at (202) 619-1157.

To facilitate identification, please refer to Common Identification Number A-17-01-02001 in all correspondence relating to this report.

Attachment
cc:
Janet Hale
Assistant Secretary for
Budget, Technology, and Finance

George H. Strader
Deputy Assistant Secretary, Finance

Department of Health and Human Services

# OFFICE OF INSPECTOR GENERAL

# REPORT ON THE FINANCIAL STATEMENT AUDIT OF THE CENTERS FOR MEDICARE AND MEDICAID SERVICES FOR FISCAL YEAR 2001


JANET REHNQUIST
INSPECTOR GENERAL

FEBRUARY 2002
A-17-01-02001

ERNST & YOUNG

■ Ernst & Young LLP
1225 Connecticut Avenue, N.W.
Washington, D.C. 20036

■ Phone: (202) 327-6000
www.ey.com

## Report of Independent Auditors

To the Inspector General of the
Department of Health and Human Services, and
the Administrator of the Centers for Medicare & Medicaid Services

We have audited the consolidating balance sheets of the Centers for Medicare & Medicaid Services, (CMS), an operating division of the Department of Health and Human Services as of September 30, 2001 and 2000, and the related consolidating statements of net costs for the fiscal years then ended and the consolidating statement of changes in net position, consolidated statements of financing, and combined statements of budgetary resources for the fiscal year ended September 30, 2001. These financial statements are the responsibility of the CMS's management. Our responsibility is to express an opinion on these financial statements based on our audits. The Medicaid Program, a major CMS administered program, had total assets of $13.4 billion and $12.3 billion as of September 30, 2001 and 2000, and total net costs of $130.4 billion and $118.7 billion for the years then ended. The Medicaid Program financial information, which is included in the CMS's consolidated and combined financial statements, was audited by other auditors whose report has been furnished to us, and our opinion and comments herein as they relate to Medicaid financial information are based solely on the report of other auditors.

We conducted our audits for the years ended September 30, 2001 and 2000 in accordance with auditing standards generally accepted in the United States; the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States; and Office of Management and Budget (OMB) Bulletin 01-02, *Audit Requirements for Federal Financial Statements*. These standards and requirements require that we plan and perform the audits to obtain reasonable assurance about whether the financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe that our audits provide a reasonable basis for our opinion.

In our opinion, based on our audits, and the reports of other auditors, the financial statements referred to above present fairly, in all material respects, the financial position of the CMS as of September 30, 2001 and 2000, and its net costs for the years then ended, and the changes in net position, budgetary resources, and its reconciliation of net costs to budgetary obligations for the fiscal year then ended September 30, 2001, in conformity with accounting principles generally accepted in the United States.

Our audits were conducted for the purpose of expressing an opinion on the financial statements referred to in the first paragraph. The information in the Management's Discussion and Analysis (MD&A) and the Supplemental Information are not a required part of the CMS's financial statements, but is considered supplementary information required by OMB Bulletins 97-01, as amended, and 01-09 as applicable, *Form and Content of Agency Financial Statements*. Such information has not been subjected to the auditing procedures applied by us and the other auditors in the audit of the financial statements, and accordingly, we express no opinion on it.

In accordance with *Government Auditing Standards*, we have also issued our reports dated January 9, 2002, on our consideration of the CMS's internal control over financial reporting and on our tests of its compliance with certain provisions of laws and regulations. Those reports are an integral part of an audit performed in accordance with *Government Auditing Standards* and should be read in conjunction with this report in considering the results of our audit.

Ernst & Young LLP

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## Report of Independent Auditors on Compliance with Laws and Regulations

To the Inspector General of the
Department of Health and Human Services, and
the Administrator of the Centers for Medicare & Medicaid Services

We have audited the consolidating balance sheets of the Centers for Medicare & Medicaid Services (CMS), an operating division of the Department of Health and Human Services, as of September 30, 2001 and 2000, and the related consolidating statements of net costs for the fiscal years then ended and the consolidating statement of changes in net position, consolidated statements of financing, and combined statements of budgetary resources for the fiscal year ended September 30, 2001; and have issued our report thereon dated January 9, 2002. The Medicaid Program, a major CMS administered program, had total assets of $13.4 billion and $12.3 billion as of September 30, 2001 and 2000, and total net costs of $130.4 billion and $118.7 billion for the years then ended. The Medicaid Program financial information, which is included in CMS's consolidated and combined financial statements, was audited by other auditors whose report has been furnished to us, and our opinion and the comments reflected herein, insofar as they relate to Medicaid financial information, are based solely on the report of other auditors.

We conducted our audits in accordance with auditing standards generally accepted in the United States; the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States; and Office of Management and Budget (OMB) Bulletin No. 01-02, *Audit Requirements for Federal Financial Statements*.

The management of the CMS is responsible for complying with laws and regulations applicable to the CMS. As part of obtaining reasonable assurance about whether the CMS's financial statements are free of material misstatement, we performed tests of its compliance with certain provisions of laws and regulations, noncompliance with which could have a direct and material effect on the determination of financial statement amounts and certain other laws and regulations specified in OMB Bulletin 01-02, including the requirements referred to in the Federal Financial Management Improvement Act of 1996 (FFMIA). We limited our tests of compliance to these provisions and we did not test compliance with all laws and regulations applicable to the CMS. We caution that noncompliance may occur and not be detected by the tests performed and that such testing may not be sufficient for other purposes.

The results of our tests disclosed no instances of noncompliance with the laws and regulations discussed in the preceding paragraph exclusive of FFMIA that are required to be reported under *Government Auditing Standards* or OMB Bulletin 01-02.

Under FFMIA, we are required to report whether the CMS's financial management systems substantially comply with the Federal financial management systems requirements, applicable Federal accounting standards, and the United States Standard General Ledger at the transaction level. To meet this requirement, we performed tests of compliance with FFMIA section 803(a) requirements.

The results of our tests disclosed instances in which the CMS's financial management systems did not substantially comply with certain requirements discussed in the preceding paragraph. We have identified the following instances of noncompliance.

- CMS does not have an integrated accounting system to capture expenditures at the Medicare contractor level, and certain aspects of the existing financial reporting system does not conform to the requirements currently specified by the Joint Financial Management Improvement Program.

- Weaknesses identified in CMS's Central Office and Medicare financial management systems' access and application controls are significant departures from requirements specified in OMB Circulars A-127, *Financial Management Systems*, and A-130, *Management of Federal Information Resources.*

As reported by CMS in Footnote 11 to the financial statements referenced above, certain claims submitted by providers do not comply with Medicare laws and regulations.

The Report of Independent Auditors on Internal Control and our separate management letter includes information related to the financial management systems that were found not to comply with the requirements, relevant facts pertaining to the noncompliance, and our recommendations related to the specific issues presented. It is our understanding that management agrees with the facts as presented, and that relevant comments from the CMS's management responsible for addressing the noncompliance, including management's proposed action plan, are provided as an attachment to this report.

Providing an opinion on compliance with certain provisions of laws and regulations was not an objective of our audit and, accordingly, we do not express such an opinion.

This report is intended solely for the information and use of the management of CMS and the Department of Health and Human Services, OMB, and Congress, and is not intended to be and should not be used by anyone other than these specified parties.

Ernst & Young LLP

January 9, 2002

ERNST & YOUNG

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## Report of Independent Auditors on Internal Control

To the Inspector General of the
Department of Health and Human Services, and
the Administrator of the Centers for Medicare & Medicaid Services

We have audited the consolidating balance sheets of the Centers for Medicare & Medicaid Services, (CMS), an operating division of the Department of Health and Human Services (DHHS) as of September 30, 2001 and 2000, and the related consolidating statements of net costs for the fiscal years then ended and the consolidating statement of changes in net position, consolidated statements of financing, and combined statements of budgetary resources for the fiscal year ended September 30, 2001; and have issued our report thereon dated January 9, 2002. The Medicaid Program, a major CMS administered program, had total assets of $13.4 billion and $12.3 billion as of September 30, 2001 and 2000, respectively and total net costs of $130.4 billion and $118.7 billion for the years then ended. The Medicaid Program financial information, which is included in CMS's consolidated and combined financial statements, was audited by other auditors whose report has been furnished to us, and our opinion and the comments reflected herein, insofar as they relate to Medicaid financial information, are based solely on the report of other auditors.

We conducted our audits in accordance with auditing standards generally accepted in the United States; the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States; and Office of Management and Budget (OMB) Bulletin 01-02, *Audit Requirements for Federal Financial Statements*.

In planning and performing our audits, we considered CMS's internal control over financial reporting by obtaining an understanding of the agency's internal control, determined whether internal control had been placed in operation, assessed control risk, and performed tests of controls in order to determine our auditing procedures for the purpose of expressing our opinion on the financial statements. We limited our internal control testing to those controls necessary to achieve the objectives described in OMB Bulletin 01-02. We did not test all internal control relevant to operating objectives as broadly defined by the Federal Managers Financial Integrity Act, such as those controls relevant to ensuring efficient operations. The objective of our audits was not to provide assurance on internal control. Consequently, we do not provide an opinion on internal control.

CMS management is responsible for establishing and maintaining internal control. In fulfilling this responsibility, estimates and judgments by management are required to assess the expected benefits and related costs of internal control policies and procedures. The objectives of internal control are to provide management with reasonable, but not absolute, assurance that assets are safeguarded against loss from unauthorized use or disposition, and that transactions are executed in accordance with management's authorization and recorded properly to permit the preparation of financial statements in conformity with accounting principles generally accepted in the United States; and data that support reported performance measures are properly recorded and accounted for to permit preparation of reliable and complete performance information. Because of inherent limitations in any internal control, errors, and irregularities may nevertheless occur and not be detected. Also, projection of any evaluation of internal control to future periods is subject to the risk that procedures may become inadequate because of changes in conditions or that the effectiveness of the design and operation of policies and procedures may deteriorate.

Our consideration of the internal control over financial reporting would not necessarily disclose all matters in the internal control over financial reporting that might be reportable conditions. Under standards issued by the American Institute of Certified Public Accountants, reportable conditions are matters coming to our attention relating to significant deficiencies in the design or operation of the internal control that, in our judgment, could adversely affect the CMS's ability to record, process, summarize, and report financial data consistent with the assertions by management in the financial statements. Material weaknesses are reportable conditions in which the design or operation of one or more of the internal control components does not reduce to a relatively low level the risk that misstatements in amounts that would be material in relation to the financial statements being audited may occur and not be detected within a timely period by employees in the normal course of performing their assigned functions. Because of inherent limitations in internal control, misstatements, losses, or noncompliance may nevertheless occur and not be detected. However, we noted certain matters discussed in the following paragraphs involving the internal control and its operation that we consider to be reportable conditions. We consider the first two such matters noted—Financial Systems, Regional and Central Office Oversight and Medicare Electronic Data Processing (EDP) Controls—to be material weaknesses.

## MATERIAL WEAKNESSES

### Financial Systems, Regional and Central Office Oversight (Partial Repeat Condition)

*Background*

Although the CMS Central Office maintains the financial accounting system, produces accounting policies and procedures, and prepares financial statements, CMS's accounting structure is decentralized in that the processing of transactions, maintenance of support and reconciliations between subsidiary files and supporting documentation are performed at the contractor level. CMS contracts with approximately 50 contractors to manage and administer the Medicare program. In fiscal year (FY) ended September 30, 2001, these Medicare expenses totaled approximately $219 billion. On a monthly basis, the contractors submit "Contractor Financial Reports" to CMS for its management and monitoring of the Medicare activities.

OMB Circular A-127 requires that financial statements be the culmination of a systematic accounting process. The statements are to result from an accounting system that is an integral part of a total financial management system containing sufficient structure, effective internal control, and reliable data. CMS relies on this decentralized organization, complex and antiquated systems and ad hoc reporting to accumulate data for financial reporting due to the lack of an integrated financial accounting system at the contractor level.

Integrated financial systems, a sufficient number of properly trained personnel, and a strong oversight function are needed to ensure periodic analyses and reconciliations are completed to detect and resolve errors and irregularities in a timely manner. As deadlines for the submission of audited financial statements continue to be accelerated, the need for improved financial management accounting systems and processes become critical if CMS is to meet these deadlines.

*Further Enhancements Noted but Additional Progress is Needed*

During FY 2001, CMS continued to make progress in resolving its material weakness, noted in the FY 2000 financial statement audit report, related to the lack of an integrated financial management system and inadequate financial accounting and supervisory review processes over its more than $219 billion in Medicare expenditures. Management executed certain actions, including:

- Providing additional instruction to its Medicare contractors through additional formalized guidance and training conferences.
- Implementing/improving procedures related to performing trend analysis to validate the accuracy and completeness of financial data reported by Medicare contractors.

- Establishing a program office to work with contractors whose objectives are to implement the new CMS financial management system — Healthcare Integrated General Ledger Accounting System (HIGLAS) project.
- Restructuring the organization to form three business centers: The Center for Medicare Management, The Center for Beneficiary Choices, and The Center for Medicaid and State Operations.
- Establishing a project management team and an internal audit function to improve the performance of CMS components.
- Issuing the Chief Financial Officer FY 2001 Project Plans. The project plans identified milestones for achieving the Comprehensive Plan goals and initiatives.
- Completing the automation for the preparation of three of five required principal financial statements. The two remaining statements will be automated during FY 2002.
- Issuing additional instructions for CMS's Central/Regional Offices to implement regarding the processing and follow up of corrective action plans (CAPs) resulting from CFO audits, Statement on Auditing Standards (SAS) 70 reviews, as well as other financial management audits and reviews performed by public accounting firms, the Office of Inspector General (OIG), and the General Accounting Office (GAO).
- Performing SAS 70 reviews documenting and assessing internal control at 15 Medicare contractor sites. These reviews include assessing progress in implementing corrective actions for prior audits.
- Performing reviews to assess the effectiveness of internal control processes and validity of accounts receivable at March 31, 2001 at 12 contractor locations that noted progress in resolving prior findings at larger contractors. Such contractors comprised approximately 82% coverage of total Medicare contractors' accounts receivable balances.
- Referring an additional $2.1 billion of delinquent debt to the Treasury as a result of efforts of the debt referral process

While progress was made in upgrading its systems and improving its policies and procedures, significant financial management issues continue to impair CMS's ability to accumulate, analyze, and distribute reliable financial information. Our review of the internal control at the CMS Central Office, Regional Offices, and selected Medicare contractors disclosed weaknesses in CMS's ability to report accurate financial information on a timely basis. These weaknesses are primarily due to the absence of certain components of a fully integrated financial management system; that such absences include full accrual accounting, a double-entry general ledger system; appropriate oversight; and adequate source documentation for Medicare Program activity. Currently, Medicare contractors do not utilize uniform accounting systems that record, classify, and summarize information for the preparation of financial statements.

*Lack of Integrated Financial Management System*

CMS's financial management systems are not compliant with the Federal Financial Management Improvement Act of 1996 (FFMIA). FFMIA requires agencies to implement and maintain financial management systems that comply with Federal financial management systems requirements as defined by the Joint Financial Management Improvement Program (JFMIP). More specifically, FFMIA requires Federal agencies to have an integrated financial management system that provides effective and efficient interrelationships between software, hardware, personnel, procedures, controls, and data contained within the systems. The lack of an integrated financial management system continues to impair CMS's and the Medicare contractors' abilities to adequately support accounts receivable and other financial balances reported.

As reported in FY 2000, Medicare contractors' claims processing systems do not have general ledger capabilities, and there are limited system interfaces currently available and in use to process and prepare data for the CMS 750/751 reports. The CMS 750 /751 reports prepared by the contractors are the culmination of the transactions and activity that have transpired from the beginning of the fiscal year. Contractors monitor and track accounts receivable activity using claims processing systems, personal computer based software, and ad-hoc spreadsheet applications to tabulate, summarize and prepare the information presented on the CMS 750/751 reports.

Because the claim processing systems utilized by the Medicare contractors lack general ledger capabilities, preparing the CMS 750/751 reports is a labor intensive exercise requiring significant manual input and reconciliations between various systems and ad-hoc spreadsheet applications. The lack of double entry systems coupled with increased use of ad-hoc supporting schedules are contributing factors that increase the risk that contractors may report inconsistent, incomplete, or inaccurate information.

During FY 2001, CMS continued its efforts in its implementation of its HIGLAS for the contractor, Regional Office, and Central Office locations. HIGLAS is designed to be an integrated general ledger accounting system, which incorporates Medicare contractors' financial data including claims activity into CMS's internal accounting system. As part of this effort, CMS is also replacing its central office general ledger that accumulates all of CMS's financial activities, both programmatic and administrative, in its general ledger. Once implemented, the new system is expected to strengthen Medicare's management of its accounts receivable, allow more timely and effective collection activities on outstanding debts and enhance oversight of contractor accounting systems. HIGLAS is not expected to be fully operational until 2006.

In addition to deficiencies noted with the Medicare contractors' claims processing systems, our audit identified integration weaknesses with other CMS's systems. For example:

- Although substantially compliant, CMS's Central Office general ledger lacks certain general ledger accounts to be fully compliant with the DHHS and the Department of Treasury general ledger requirements. For example, certain budgetary general ledger accounts are not available to support FACTS II requirements. Current processes institute the use of proprietary accounts to develop its FACTS II submissions.
- The automated process to update the CMS Financial Accounting Control System utilizes a transaction code no longer entirely appropriate for posting to the general ledger. As a result, data reported to Treasury per the SF-224 may not agree with CMS general ledger.

Finally, during CMS's accounts receivable review, we noted that although certain contractors had issued Program Action Requests (PARS) to support programming to overcome system issues, the status of the PARs were not being closely monitored by the contractors. Although a formal process is performed periodically to prioritize and approve the PARs, it appears that the contractors were not monitoring the status. As a result, corrective action plans could not be maintained or implemented properly.

***Financial Analyses and Reporting—Medicare Contractors***

During FY 2001, our overall results identified improvements in internal control processes at the contractor locations. CMS Central Office has taken steps by developing policies and procedures and new program memorandums to ensure consistency in reporting and internal control processes within the contractor environment. However, because the contractors lack a formal integrated accounting system to accumulate and report financial information, the contractors are using Ad-hoc reports, which are very labor intensive to develop and utilize and increase the risk of human error, material misstatement, or omission. Through our procedures, we found that independent verification controls were not established or were not consistently applied to provide reasonable assurance that amounts reported by contractors to CMS were valid, accurately summarized and sufficiently documented. Additionally, we noted that due to the volume of transactions processed by the contractors, sufficient time and resources may not be available to thoroughly review financial data prior to submission to the Central Office.

*Medicare Contractor Accounts Receivable*

At September 30, 2001, CMS reported a net accounts receivable balance of approximately $3.1 billion, comprised of gross outstanding accounts receivable of $8.1 billion and an aggregate allowance for uncollectible accounts of $5.0 billion. Medicare contractors primarily maintain Medicare accounts receivable activity. The majority of these receivables (referred to as Non-Medicare Secondary Payer (Non-MSP)) represent contractor overpayments to providers, beneficiaries, physicians, and suppliers. The balance of these receivables represents payments for those claims for which Medicare should be the secondary rather than the primary payer (referred to as MSP).

CMS's contractors are responsible for reporting and collecting the majority of these receivables (approximately 77 percent of the total outstanding balance at year-end). During fiscal year 2001, Medicare contractors reported $8.7 billion in new accounts receivable, $7.2 billion in collections, and $1.6 billion in transfers and other adjustments to accounts receivable balances. The remaining accounts receivable activity is managed by CMS's central and regional offices.

Although processes are continually being refined and systems are currently being updated, certain weaknesses in internal control persist at the contractors. Our review of accounts receivable at nine contractors identified similar control deficiencies, although fewer occurrences, as compared to those reviews performed at September 30, 2000 and the review of Medicare Contractor Accounts Receivables at March 31, 2001.

The Medicare Accounts Receivable review as of March 31, 2001 identified improvements, especially at the larger contractors, but continued to note certain weaknesses in the contractors' processing of Non-MSP accounts receivable. The Non-MSP errors were approximated at an absolute value of $294 million at March 31, 2001 (with a net value of $240 million); representing lack of supporting documentation of about $13 million, transfer errors of $110,000, clerical errors of approximately $273 million and other errors of about $8 million. These errors were the result of an antiquated systems environment and manually intensive processes to gather data and documentation to support amounts submitted to CMS through its 750 and 751 processes. Additionally, the review noted limited supervisory reviews of manual calculations, especially in the area of calculating the contractors' Periodic Interim Payment (PIP) accrual that accounted for the two largest errors of $198 and $23 million. Further, the review noted that contractors did not consistently follow policies and procedures as it relates to the establishment and reporting of accounts that are Currently Not Collectible.

Our review of accounts receivable activities at September 30, 2001, identified similar deficiencies as follows:

- We noted an overstatement of $1.9 million in one contractor's claims accounts receivable balance due to an error in posting.
- We noted one contractor where the MSP accounts receivable balance reported could not be reconciled to the detail because of a system programming error. The differences totaled $8.1 million that were subsequently resolved.
- We noted at two contractors that limited supervisory review was performed to review the calculation of PIP and Pass-Through payments. Of 45 items selected for testing at one contractor location, 15 disclosed no evidence of supervisory review.
- We noted at one contractor that Pass-Through rate reviews were not performed on a timely basis.

Further, we noted certain issues with the calculation of the allowance for uncollectible accounts. For example, we noted one contractor that miscalculated its allowance by $4.1 million, because

the entity did not fully implement the CMS's instructions in estimating the Allowance for Uncollectible Accounts The CMS 751 report requires contractors to report an aging of accounts receivable. CMS guidelines state that the allowance for doubtful accounts receivable should be based on a systematic method which considers historical loss experience (current procedures call for five years when that is available), recent economic events, current and forecast conditions, and inherent risks.

*Medicare Contractors Reconciliation of Funds Expended*

Finally, the reconciliation of "total funds expended" on the CMS 1522, Monthly Contractor Financial Report is an important control that ensures amounts reported to CMS on this report by Medicare contractors are accurate, supported, complete, and properly classified. At the Medicare contractor level, "total funds expended" is the sum of all checks drawn and electronic fund transfer payments issued during the calendar month less voided checks and overpayment recoveries. This amount is then further classified by component into the following categories: benefit payments, PIP, accelerated payments, net suspense payments, audit reimbursement adjustments, and interest income and expenses. CMS uses certain information from this report to support the error rate and the Medicare entitlement benefits due and payable included in the financial statement.

CMS has shown improvements in its reconciliation of funds expended. In FY 2000, only one of ten contractors selected for review formally reconciled paid claims activity to "total funds expended on a monthly basis compared to the six of nine contractors selected for review in FY 2001 that were in compliance with CMS's policy. Although the remaining contractors in both years reconciled monthly using monthly reports generated from internal systems, CMS requires the monthly reconciliations to be performed using the actual paid claims tapes or related system summary reports. For audit purposes, the reconciliation is critical because the auditors must be able to obtain a file of paid claims that will reconcile to the CMS1522 before selection of a statistically valid sample of claims is reviewed. Our analysis of the CMS 1522s at nine selected Medicare contractors in FY 2001 identified the following internal control weaknesses.

- One contractor had difficulty in reconciling the Part A claims tape to the total funds expended. This was due to changes to the FISS claims processing to meet the requirement for the implementation of the Prospective Payment System on October 1, 2000. The unreconciled difference was approximately $1.3 million.
- One contractor did not have internal control in place to ensure continuity of operations that delayed the reconciliation process substantially for the January, February, March 2001 period for Part A and B. A key employee retired in December 2000. The situation was compounded by high levels of turnover in the personnel assisting in the CMS 1522 reconciliation process. Each of the Part A and Part B CMS1522s, six in total, were submitted and resubmitted between 4 and 8 times. Appropriate data was eventually received.

- At another contractor, we noted inappropriate transactions included in the CMS 1522 reconciliation to the Paid Claims Tape. For example, we noted that current month Funds Transfer payments were not included or excluded appropriately, total funds expended were reduced for the same voided checks more than once and PIP reimbursement amounts were significantly out of balance between FISS reports.

***Financial Analyses and Oversight—Regional and Central Office Oversight***

As reported in FY 2000, CMS's oversight of Medicare contractor operations and financial management controls did not provide reasonable assurance that material errors would be detected and corrected in a timely manner. One area that impacts the effectiveness of the oversight function is the complexity of CMS's decentralized environment. Currently, roles and responsibilities between the Regional and Central Offices are not fully understood and agreement reached on the depth of detailed financial management oversight to be performed in the regions and how such work will interrelate with CMS central office activities. For the oversight function to be effective, the division of responsibility should be documented with each participant agreeing and fully understanding the importance of its role in the process. Financial management related roles and responsibilities of the Central Office and the Regional Offices need to be reinforced and documented. Our discussions with management identified two of the more significant causes as (1) other program responsibilities sometimes reduces the priority of financial activities and (2) the Office of the Chief Financial Officer does not have direct authority for all financial management activities within the regional office. This has resulted in limited procedures being performed, increasing the risk of material misstatement. Regional and Central Office oversight is critically important in reducing the risk of material misstatement in the financial statements.

*CMS Central Office*

CMS's oversight function relating to financial management is primarily performed by CMS's central office where limited resources are available to adequately perform this critical task for approximately 50 Medicare contractors. Improvements in Central Office Oversight and analysis were noted, including:

- providing additional guidance to the contractor community,
- implementing/improving procedures related to performing trend analysis to validate the accuracy and completeness of financial data reported by Medicare contractors,
- drafting fourteen of twenty-one chapters of its new financial accounting policies manual with expected refinements during fiscal year 2002,
- formalizing certain financial management policies and procedures, and
- developing an internet-accessible database, which contains all financial management guidance and instructions.

However, CMS Central Office should continue to enhance its periodic analyses and oversight of information included in its financial statements. We noted the following weaknesses during our review:

- Due to limited analysis, CMS recorded an accrual for $40.0 million as an entitlement benefits due and payable even though the payment was made prior to the end of FY 2001.
- Due to limited resources, certain financial details in program memoranda were not identified during review prior to distribution to the contractors. The accounts receivable review noted a potential $40.0 million overstatement of accounts receivable due to a program memorandum activated without CMS's financial management office review.
- Supervisory reviews were not consistently performed and documented in the development of reconciliations, review of contractor submitted reports, or the development of financial statements, supporting statements, and related crosswalks. We noted several computational errors that could have been identified with the appropriate level of detailed supervisory reviews.
- The review process relating to the Contractor and Regional Office 750 and 751 reports and related fluctuation analyses needs further enhancements. Currently, CMS does not consistently document its review, perform proper follow-up on unusual fluctuations or ensure resolution of all questions that arise. For example, as discussed above, we noted an instance where one contractor overstated its receivable balance by $198 million. CMS Central Office indicated that they had identified the difference but failed to follow-up to ensure resolution. Additionally, our procedures noted that four contractors could not adequately support the reclassification/adjustment line. For example, one contractor could not support approximately $7 million in adjustments to the reclassification/adjustment line.

Additionally, the GAO's *Standards for Internal Control in the Federal Government* requires that internal control and all transactions need to be clearly documented in properly maintained management directives, administrative policies, or operating manuals. Without adequate policies, CMS increases the risks that the financial statements are not being prepared and presented in a timely, consistent, and accurate manner. During FY 2001 CMS Central Office initiated a project for which they hired an outside consultant to assist in preparing formalized procedures; however, the project had not been completed at fiscal year-end.

*CMS Regional Office*

Oversight duties for contractor processes and systems are shared by the Central and Regional Offices, with the Regional Offices playing a critical oversight role in that they are the first point of contact for the contractors. Medicare Regional Offices are responsible for:

- Monitoring Medicare contractors to ensure that claims are processed in a timely manner.
- Ensuring benefit payments are made as specified by law.
- Assessing whether contractors have adequate controls in place to prepare financial reports and to determine that the reports are valid, accurate, and complete.
- Performing assessments to ensure corrective actions are taken to resolve prior findings.
- Monitoring contractors' compliance with systems security requirements through the performance of on-site reviews.
- Coordinating financial and system related engagements at Medicare Contractors which include negotiating and assisting in providing responses to findings.
- Conducting Medicare contractor performance evaluation and quality reviews.
- Reviewing budget requests, and negotiating and recommending approval of Medicare contractor budgets with Central office.
- Conducting financial and internal control reviews of Medicare contractor activities.
- Preparing financial reports and related analysis related to Regional Office activities.

During FY 2001, we visited two regional offices to assess the Regional Office oversight function and found that certain procedures were not being performed to ensure financial data provided by Medicare contractors is reliable, accurate, and complete. CMS management identified the most significant cause as inadequate resources. We noted the following:

- Regional Offices do not have procedures in place to monitor the 1521/1522 reports. While the 1521 report identifies contractor draws on the letter of credit, the 1522 report identifies monthly claims and non-claims payments. On a monthly basis, the Regional Office receives the 1521/1522 reports along with a reconciliation of funds expended from the contractors. Current procedures dictate only a brief scan of the reports to detect any obvious errors and assess the timeliness of transmission. No procedures were performed to ensure amounts were properly reported, reconciled, and supported by adequate documentation. During our review, we noted one contractor who did not maintain supporting documentation for expenditure categories submitted on the 1522. CMS management indicated that one region performed 1522 reviews at three contractors during FY 2001. Based on the results of the review, CMS expects to expand the reviews to more regions during FY 2002.
- During FY 2001, the Regional Offices were directed to perform trending of their accounts receivable activity that is submitted to CMS on a quarterly basis. Our review of the trending analyses performed for September 30, 2001 identified the use of improper formats, incorrect data, and insufficient follow-up.
- Regional Offices do not consistently review accounts receivable balances included on the Contractor 750/751 reports to ensure balances are proper. For example, we identified two separate errors at one contractor totaling $3.1 million in the classification of amounts. If detailed reviews had been performed, this difference may have been identified and resolved in a more timely manner.

- Audit and Reimbursement Contractor Performance Evaluation (CPE) reviews are performed to evaluate the contractor's performance in safeguarding program assets. These reviews include the evaluation of interim rate accuracy, controls over the processing of overpayments, and provides recommendations to improve contractor performance. During FY 2001, CMS used a risk-based approach to select contractors to review. However, only 6% of the contractor community had audit and reimbursement reviews. Due to the lack of reviews completed, there is an increased risk that Medicare funds are not being safeguarded against inappropriate program expenditures.
- During FY 2001, CMS used a risk-based approach and selected five contractors for five Audit Quality Review Program (AQRP) each or 25 reviews in total. Although this was a decrease of 100 reviews from FY 2000, the regional offices did not perform additional procedures to ensure appropriate coverage of the contractors.
- During FY 2001, at one Regional Office, we noted that no documentation existed to support the follow-up of prior year AQRP findings and the monitoring of related corrective action plans. The AQRP function provides assurance that contractors' procedures in the audit and settlement of cost reports are in accordance with CMS requirements. If corrective actions are not taken, the benefits of the process are lost, for the deficiencies continue to exist.

Additionally, during CMS's accounts receivable review, we noted that contractor personnel inquiries to Regional Offices relating to preparation of required CMS reports, approval of system modifications, interpretation of CMS guidance, and transfers of accounts receivable are not always responded to in a timely fashion. While efforts were made to be responsive to contractors' questions, we noted three cases where responses from the Regional Offices took more than several months. Additionally, we noted that even when responses to contractor questions were provided, the responses were not provided to all contractors—only the contractor posing the question. Lack of open and clear communication of the interpretation may lead to inconsistent application of policy. Finally, we noted that in certain cases guidance or interpretations provided by the Regional Offices may be inconsistent with those interpretations provided by the Central Office. As a result, the contractors may change their processes only to find that further refinements will still be required to be compliant with CMS policy.

The GAO's *Standards for Internal Control in the Federal Government* indicates that internal control monitoring should assess the quality of performance over time and ensure that findings of audits and other reviews are promptly resolved. Without appropriate monitoring and oversight of contractor operations, deficiencies in internal control may allow material misstatements to occur without being identified in a timely manner.

*Recommendation*

We recommend that CMS continue to develop and refine its financial management systems and processes to improve its accounting, analysis, and oversight of Medicare activity. Specifically, we recommend CMS:

- Establish an integrated financial management system for use by Medicare contractors and CMS's Central and Regional Offices to promote consistency and reliability in recording and reporting financial information, including accounts receivable and claim activity. Additionally, CMS should continue its efforts to promote uniformity of Medicare contractors' systems.
- Refine the divisions of responsibility between Office of the Chief Financial Officer and the Program and Regional Offices to ensure financial management activities are adequately performed and staffed and financial information generated is complete, valid, and properly valued and that corrective actions to prior findings are monitored. Additionally, CMS should assess whether the division of responsibility are properly documented and that all organizations are in agreement and fully understand the importance of their role.
- Continue to refine its procedures to provide a mechanism for CMS Central and Regional Offices to monitor contractors' activities and enforce compliance with CMS financial management procedures. This may include:

  - Obtaining detailed subsidiary ledgers and related support from contractors for the CMS Regional and Central Offices and reviewing subsidiary ledgers for reasonableness;
  - Reviewing reconciliations, including the reconciliation of total funds expended, and trend analyses prepared by the contractors consistently on a periodic basis;
  - Documenting in writing and tracking responses provided to questions arising from the contractors to ensure a full understanding and consistency of financial activity processes;
  - Consistently reviewing high level exception driven analysis and developing an archiving mechanism so that historical information is available for future trending; and

  - Enhancing oversight procedures to monitor the implementation of control procedures to provide independent checks of validity, accuracy, and completeness of amounts reported to CMS. HIGLAS is expected to provide a foundation for improving oversight activities over financial activities.
- Continue to develop and implement formalized policies and procedures in the preparation and analyses of financial reports. Additionally, refinement of policies and procedures is still needed to ensure that procedures are properly and consistently performed at the contractors and the Regional Offices.
- Implement a process of supervisory review at the Central Office, Regional Offices and contractor sites to identify errors in a more timely fashion.
- Provide additional training for financial personnel at the CMS Central Office, the Regional Offices, and for the Medicare contractors to ensure that personnel understand the importance of posting entries correctly, performing account analyses and reconciliations, maintaining supporting documentation, and updating their knowledge of financial reporting requirements.
- Establish and implement corrective action plans to resolve system deficiencies that impair the contractors' ability to support and report accurate amounts. Corrective action plans should be developed by the contractors in conjunction with the Central and Regional offices to ensure they identify specific requirements of claims processing systems to ensure they not only meet the reporting needs of the CMS Central Office, but also the contractor operating environments.
- Expand its centralized database to improve communications throughout CMS and its contractors. The database would be a mechanism for contractors to share experiences or leading practices, including short-term systematic resolutions to global issues, ask questions of CMS, provide answers or interpretations to contractor related questions, and release CMS guidance or other types of communications that impact the various contractors.

**Medicare Electronic Data Processing (EDP) Controls (Repeat Condition)**

**Background and Scope of Review**

The CMS relies on extensive electronic data processing (EDP) operations at both its Central Office and Medicare contractor sites to administer the Medicare program and to process and account for Medicare expenditures. Internal control over these operations are essential to ensure the integrity, confidentiality, and reliability of critical data while reducing the risk of errors, fraud, and other illegal acts.

The CMS Central Office systems are used to maintain administrative data, such as Medicare enrollment, eligibility, and paid claims data, and process all payments for managed care. The Medicare contractors and data centers use several standard "shared" systems to process and pay fee-for-service claims. All of the shared systems are maintained by "system maintainers" and are

interfaced with CMS's Common Working File (CWF) to obtain authorization to pay claims and to coordinate Medicare Part A and Part B benefits. This network accounted for and processed $191.8 billion in Medicare expenditures during FY 2001.

Our review of EDP internal control covered both general and application controls and did not include management or operational controls. General controls involve the entity-wide security program, access controls (physical and logical), application development and program change controls, segregation of duties, operating systems software, and service continuity. General controls impact the integrity of all applications operating within a single data processing facility and are critical to ensuring the reliability, confidentiality, and availability of CMS data. Application controls include input, processing, and output controls related to specific CMS EDP applications.

We completed general control reviews at the CMS Central Office and three Medicare data processing facilities that support the Medicare contractors sampled. In addition, we assessed application controls of the Fiscal Intermediary Standard System (FISS) and the VIPS Medicare System (VMS) at two separate contractors. We also assessed application development and maintenance controls at five system maintainers. At 10 contractors, we updated the status of findings reported upon in FY 2000 concerning general and application controls.

We reviewed the results of CMS-sponsored external vulnerability assessments performed during FY 2001 at the Central Office and three Medicare contractors. We also reviewed the results of CMS-sponsored SAS 70 independent service auditor reviews performed during FY 2001 for fifteen Medicare contractors as well as OIG reviews of selected areas. We also noted that CMS has implemented a self-assessment process for Medicare contractor security and has developed a substantial body of knowledge on known system vulnerabilities. The results of these CMS-sponsored assessments provided substantial and beneficial information related to weaknesses that need to be addressed.

**Overview of Results of FY 2001 EDP Review**

In the course of the FY 2001 EDP review procedures, we continued to find numerous EDP general control weaknesses at the Medicare contractors, system maintainers, and the CMS Central Office. Such weaknesses do not effectively prevent (1) unauthorized access to and disclosure of sensitive information, (2) malicious changes that could interrupt data processing or destroy data files, (3) improper Medicare payments, or (4) disruption of critical operations. Further, weaknesses in the contractors' entity-wide security structure do not ensure that EDP security controls are adequate and operating effectively. Because certain financial reconciliation and report processes within CMS continue to evolve and require further improvement, the general and application controls related to access controls, systems software and application software development and change controls are critically important to CMS to ensure the integrity, confidentiality, and availability of sensitive Medicare data. In aggregate, the matters noted below are a material weakness.

**Medicare Contractors**

Weaknesses were identified at the Medicare contractors in five primary types of controls, as follows:

- Entity-wide security programs
- Access controls (physical and logical)
- Systems software
- Application software development and change controls
- Service continuity

CMS' External Business Partner Systems Security Initiative is believed to have the potential as a foundation program to address the vulnerabilities if adequately resourced and properly implemented and monitored.

**Entity-wide security programs.** These programs are intended to ensure that security threats are identified, risks are assessed, control objectives are appropriately designed and formulated, relevant control techniques are developed and implemented, and managerial oversight is consistently applied to ensure the overall effectiveness of security measures. Security programs typically include formal policies on how and which sensitive duties should be separated to avoid conflicts of interest. Similarly, policies on background checks during the hiring process are usually stipulated. Entity-wide security programs afford management the opportunity to provide appropriate direction and oversight of the design, development, and operation of critical systems controls. Inadequacies in these programs can result in inadequate access controls and software change controls affecting mission-critical, computer-based operations. Entity-wide security plan control weaknesses were identified at the FY 2001 review sites, including the Central office, and such weaknesses continue at certain sites reviewed in FY 2000. Certain contractors and the central office have not formalized all of their security plans and related programs that address federally mandated requirements.

**Access controls (physical and logical).** Access controls ensure that critical systems assets are physically safeguarded and that logical access to sensitive computer programs and data is granted only when authorized and appropriate. Access controls over computer operating systems and data communications software are also closely related. These controls help ensure that only authorized staff and computer processes access sensitive data in an appropriate manner. Weaknesses in such controls can compromise the integrity of sensitive program data and increase the risk that such data may be inappropriately used and/or disclosed. Access control weaknesses continue to be identified and represent a significant risk to the Medicare program. Such weaknesses involved the configuration of access control software, policies and procedures for ongoing monitoring and review of suspected access violations, consistent security controls between mainframe and Internet-connected Medicare systems, and physical access to Medicare

data centers. During penetration vulnerability testing at four Medicare contractors and the CMS Central Office, we identified weaknesses that relate to dial-in access, user account and password management, Internet security, and systems software configuration.

**Systems software.** Systems software is a set of computer programs designed to operate and control the processing activities for a variety of applications on computer hardware and related equipment. The systems software helps coordinate the input, processing, output, and data storage associated with all of the applications that are processed on a specific system. Some systems software is designed to change data and programs without leaving an audit trail. Problems related to managing routine changes to systems software to ensure an appropriate implementation and related configuration controls were identified. Such problems could weaken critical controls over access to sensitive Medicare data files and operating system programs.

**Application software development and change controls.** We found that the prior control weakness related to the Medicare fiscal intermediary data centers with access to program source code for the Fiscal Intermediary Standard System (FISS) continues to be partially unresolved. With such access, Medicare data centers are able to implement local changes to FISS application programs. Such access may be abused, resulting in the implementation and processing of unauthorized programs at the intermediary data centers. While CMS requires such contractors to restrict local changes to emergency situations, local changes are often not subjected to the same controls that may exist in the standard change control processes intended by the system maintainer. We also found that several contractors and system maintainers did not have formal change control processes and lacked sufficient documentation of systems changes.

**Service continuity.** Continuity plans provide a means for re-establishing both the automated and administrative processes related to the Medicare program in the event of a system failure. We found that several contractors did not have up-to-date, completed, and tested continuity plans to assure uninterrupted processing of Medicare data.

**CMS Central Office**

Our review of general controls at the CMS Central Office indicated that while several important initiatives have been started, several weaknesses continued to exist in the controls. Such weaknesses were identified in entity-wide security plans, access controls, application development and change controls, operating system software controls, and service continuity. Most of CMS's Central Office initiatives to address the identified control weaknesses were not completed at the end of FY 2001.

*Recommendation*

CMS continues to rely upon automated systems processed by the Medicare contractors for the consistent administration of virtually all aspects of the program. Detailed findings and

recommendations for each full-scope review and follow-up review have been communicated to the OIG and CMS management.

In FY 2001, CMS made considerable progress in identifying weaknesses in automated processing systems. CMS identified several weaknesses in the performance of vulnerability assessments, SAS 70 control reviews, the compilation of Medicare contractor controls self-assessments, OIG assessments, and our procedures. This effort provides a base line for improvement. In discussing the results of these assessments with management, we understand that CMS embraces the need to assess the risks inherent in each vulnerability, assess priorities, and seek additional resources as necessary to correct known deficiencies. Unless adequate resources are made available to address these deficiencies, it is likely that symptoms of these weaknesses will continue to be identified.

CMS management should, in conjunction with the Central Office and Medicare contractors and system maintainers that support the overall development, maintenance, and processing of the Medicare automated systems, continue to develop, implement, and monitor cost-effective controls to include:

- Consistent adherence to the OMB Circular A-130 guidelines for entity-wide security plans to ensure appropriate consideration is given to safeguarding Medicare data.
- Consistent and effective physical and logical access procedures, including administration and monitoring of access by Medicare contractor and Central Office personnel in the course of their job responsibilities.
- Consistent and effective procedures over the implementation, maintenance, access, and documentation of operating systems software products used to process Medicare data. Appropriately controlled operating systems software products are fundamental to the integrity of the processing of Medicare data.
- Attention to appropriate segregation of duties to ensure accountability and responsibility for access to Medicare applications and data are appropriately assigned.
- Updated and appropriately documented service continuity procedures to recover Medicare processing in the event of a system outage.

## REPORTABLE CONDITIONS

### Medicare Entitlement Benefits Due and Payable (Repeat Condition)

Medicare entitlement benefits due and payable, totaling approximately $27.1 billion at September 30, 2001, represent the cost of services provided to Medicare beneficiaries but not paid at the end of the fiscal year. While the largest component, totaling $27.0 billion, represents an estimate developed by the Office of Actuary (OACT) and is based on historical trends of completeness that take into consideration estimated deductible and coinsurance amounts, a second component, totaling $44.0 million, is primarily prior period adjustments to managed care (HMO) payments that were identified prior to September 30, 2001 but paid during October of the following fiscal year.

During FY 2001, CMS took certain corrective actions to improve its processes surrounding Medicare Entitlement Benefits Due and Payable, as follows:

- Development of a formalized document illustrating an overview of the estimation process, the sources of information, and the roles and responsibilities within the process;
- Improved analysis of the data produced—both in the OACT office and the Office of Financial Management; and
- Improved planning of the estimation process that identified target dates that enabled the acceleration of the estimate by more than one month.

However, current procedures may not be adequate to detect errors in data used in future projections. Specifically, we noted the following:

- During fiscal year 2002, CMS developed formalized-written policies and procedures detailing its processes related to Medicare entitlement benefits due and payable. However, during FY 2001, although CMS had established procedures for validating and reviewing source data and estimates used in the preparation of the overall entitlement benefits due and payable estimate, additional enhancements were necessary to ensure reliability of the estimates.
- Of the $44 million related to the HMO component, we noted that $40 million was inaccurate due to the payment on September 30, 2001 of those adjustments identified in September. These payments in past years were included as a liability on CMS's financial statements because they had not been paid until the following fiscal year. CMS accelerated the payment due to new requirements under the Balanced Budget Act of 1997.
- Differences were noted between claims on the payment floor, including a $15.6 million and $7.0 million difference between the amounts reported to CMS and detailed support

maintained at two contractors; outstanding checks; and periodic interim payment amounts reported by the contractor to CMS and supporting documentation maintained at the contractors.

- STAR data, which are CMS's primary source for cost settlement information, are inconsistent with cost settlement information that is recorded on the CMS 1522 reports prepared by the contractors. Consequently, STAR data are adjusted to reconcile to balances included on the CMS 1522 that is considered by CMS to be more reliable.

*Recommendation*

We recommend that:

- Enhanced guidance be provided to contractors to emphasize the need for accurate reporting of requested data. CMS is in the process of developing a Medicare contractor financial manual to enhance the contractors' ability to map their internal control environment and to assist with training on internal control requirements.
- CMS improve its oversight of contractor-provided information to ensure accuracy of balances. This would include requesting copies of report runs and detailed support on a test basis as appropriate, and critically assess the appropriateness of estimates provided and documentation of management's conclusion.
- CMS assess the feasibility of modifying STAR data to accurately reflect cost settlement activities, adding necessary information on the date that a cost settlement is finalized, and when it is paid.
- Formalized policies and procedures should be enhanced to ensure:
  - sources of data are documented,
  - amounts extracted are complete, accurate, and valid,
  - input to the incurred but not reported claim estimation model agrees with data in the general ledger and financial statements, and
  - analyses are performed within the Office of Financial Management and the OACT to explain unusual fluctuations in input data and results. This would entail an on-going analysis throughout the fiscal year of data elements used in the year-end estimation model and HMO calculation.

**Medicaid Claims Estimated Improper Payments (Repeat Condition)**

No methodology currently exists for estimating the range of improper Medicaid payments on a national level. The OIG has been reviewing a statistically valid sample of Medicare claims for the last several years and has determined an estimated range of improper payments out of the total fee for service payments processed by CMS. The majority of the errors fell into four broad categories: insufficient or no documentation, lack of medical necessity, non-covered or unallowable service, and incorrect coding. The results of this sampling provide CMS with useful

information in helping to reduce the overall Medicare improper payments. With no similar methodology in place for the Medicaid Program, CMS is unable to draw any conclusions at a national level on improper Medicaid payments. Because Medicaid is a grant program, any sampling would need to be done in conjunction with the states.

*Recommendation*

We recommended in our prior report that CMS work with the states to develop procedures for the implementation of a methodology to determine the range of improper payments in the Medicaid Program.

CMS has made some progress in developing a pilot project and has contracted with outside parties to assist in developing a consistent methodology.

We continue to recommend that the workgroup be staffed as soon as possible and that work begin on development of a methodology that can be implemented in all the states on a consistent basis.

* * * * * * * *

In addition, we considered CMS's internal control over Required Supplementary Stewardship Information (RSSI) by obtaining an understanding of the agency's internal control, determined whether internal control had been placed in operation, assessed control risk, and performed tests of controls as required by OMB Bulletin No. 01-02 and not to provide assurance on internal control. Our procedures with respect to trust fund projections consisted of comparing amounts reflected in the Required Supplementary Stewardship Information to Trustee reports and spreadsheets prepared by the OACT and did not include re-performance of actuarial computations or tests of underlying computations or related controls, if any. Accordingly, we do not provide an opinion on such controls.

In addition, with respect to internal control related to performance measures reported in the Management's Discussion and Analysis (MD&A), we obtained an understanding of the design of internal control relating to the existence and completeness assertions and determined whether they have been placed in operation, as required by OMB Bulletin 01-02. Our procedures were not designed to provide assurance on internal control over reported performance measures, and, accordingly, we do not provide an opinion on such controls.

We noted other matters involving internal control over financial reporting, which we have reported to management in a separate letter dated January 9, 2002.

This report is intended solely for the information and use of the management of CMS and the Department of Health and Human Services, OMB, and Congress, and is not intended to be and should not be used by anyone other than these specified parties.

Ernst + Young LLP

January 9, 2002

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Baltimore, MD 21244-1850

Ernst & Young L.L.P.
1225 Connecticut Avenue, N.W.
Washington, D. C. 20036

Dear Sir:

This letter is in response to your audit report on the Centers for Medicare & Medicaid Services' (CMS) fiscal year (FY) 2001 financial statements. Your report identifies two material weaknesses: 1) Financial Systems, Regional and Central Office Oversight and 2) Medicare Electronic Data Processing (EDP) Controls. Each of these weaknesses is repeated from the FY 2000 audit of CMS's financial statements.

The CMS generally concurs with the findings and descriptions of weaknesses. As noted in your report, CMS has continued to make significant improvements in the area of financial management during FY 2001. Specifically, we were successful in implementing many of the initiatives developed in the Chief Financial Officer (CFO) Comprehensive Plan for Financial Management that highlights CMS's key financial management activities, projects, and activities. These initiatives have greatly improved the consistency of financial reporting and Medicare contractor oversight. Additionally, we continue to stress to our Medicare contractors CMS's expectations and commitment to improving financial management and emphasize the importance of debt referral and internal controls.

We recognize that these weaknesses predominantly result from CMS's lack of an integrated general ledger accounting system that captures financial data at the Medicare contractor level. The Healthcare Integrated General Ledger Accounting System (HIGLAS) project, which is a state-of-the-art financial management system that will fully integrate CMS's accounting systems with those of our Medicare contractors, is underway. HIGLAS will strengthen CMS's financial management by standardizing the collection, recording, and reporting of Medicare financial information, as well as satisfy Agency accounting needs. CMS has awarded the HIGLAS contract, pilots are underway at two Medicare contractors and a HIGLAS project office has been established.

Although we are pleased with these results, we acknowledge the challenges we must address to remain committed to our goal of providing reliable financial information regarding the operation of CMS's programs. We will continue to track our progress and report it to the Department on a regular basis.

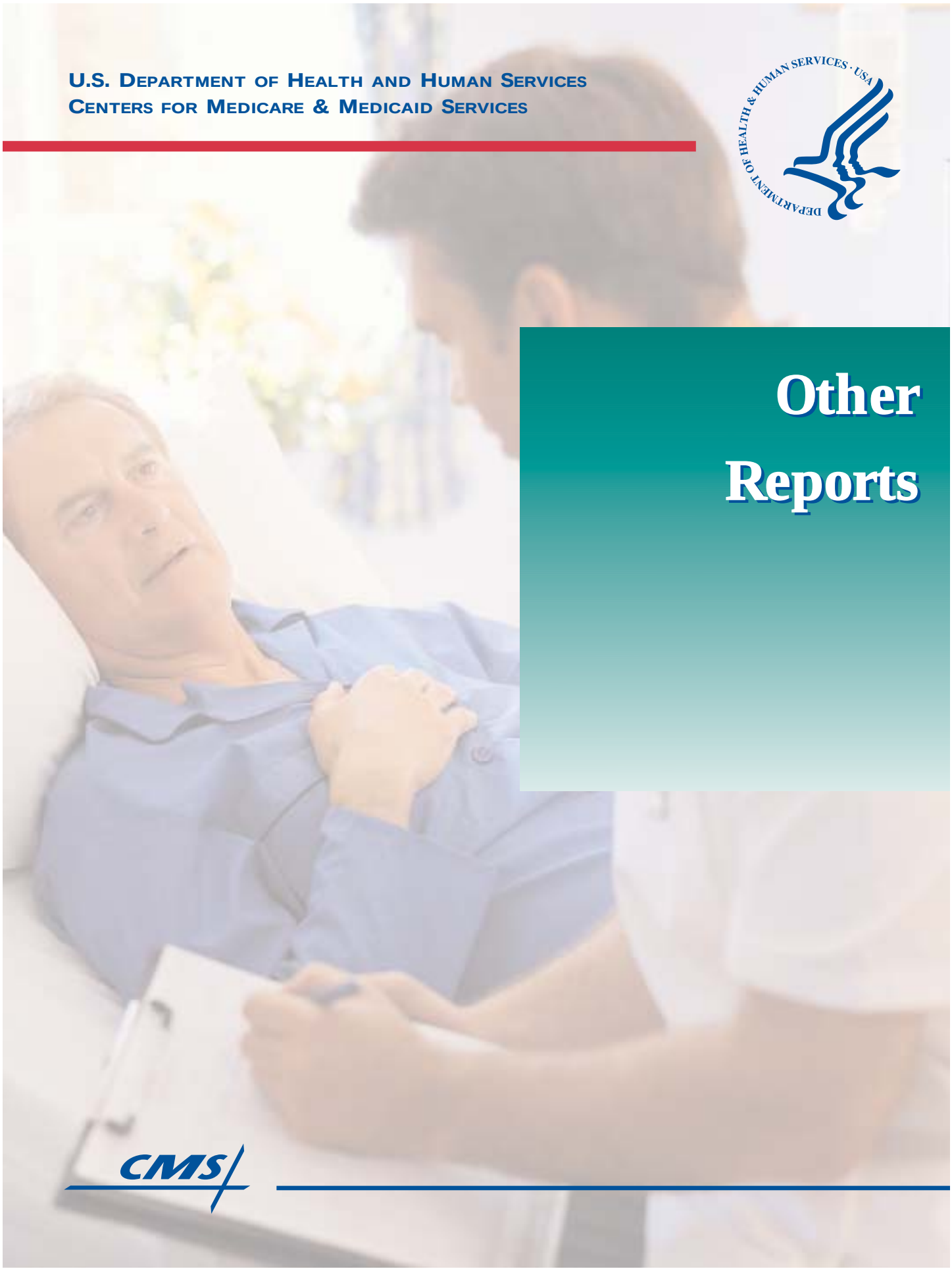
I would also like to thank your office for their diligent work in completing the audit within the accelerated timeframes.

Sincerely,

A. Michelle Snyder

A. Michelle Snyder
Chief Financial Officer

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services



# Other Reports

CMS

# REPORT ON FEDERAL MANAGERS' FINANCIAL INTEGRITY ACT

The Federal Managers' Financial Integrity Act (FMFIA) requires agencies to report annually if: 1) they have reasonable assurance that their management controls protect their programs and resources from fraud, waste, and mismanagement, and if any material weaknesses exist in their controls, and 2) their financial management systems conform with Federal financial management systems requirements and Federal accounting standards.

CMS assesses its management controls and financial management systems through: 1) management control reviews, 2) the financial audit, 3) Office of Inspector General (OIG) audits, 4) management self-certifications, and 5) other review mechanisms, such as Statement of Auditing Standards (SAS-70) internal control reviews. As of September 30, 2001, the management controls and financial management systems of CMS provided reasonable assurance that the objectives of FMFIA were achieved. However, two material weaknesses (repeated from prior years) existed and a noncompliance was identified during the Chief Financial Officer financial audit.

## Material Weakness 1: Financial Systems, and Regional and Central Office Oversight

Overall, the Medicare contractors have made significant improvements in maintaining supporting records for Medicare activities and year-end balances. However, because the contractors lack a formal, integrated accounting system to accumulate and report financial information, they use ad hoc, labor-intensive reports, which increases the risk of material misstatement or omission. In addition, Medicare contractor controls over accounts receivable continue to need improvement.

At the CMS central office, procedures were implemented that resulted in adjustments to accounts receivable balances reported by the contractors. However, these procedures did not ensure that accounts receivable activity included on the contractor financial reports was properly supported by detailed transactions. In addition, the CMS central office did not have formal procedures documenting financial statement and financial reporting analysis functions, and regional offices did not perform certain procedures to help ensure that financial information provided by the contractors was reliable, accurate, and complete.

CMS continues to provide instructions and guidance to the Medicare contractors and our central and regional offices. We continue to contract with Independent Public Accountants (IPAs) to test financial management internal controls and to analyze accounts receivable at Medicare contractors. In addition, contractor performance evaluation (CPE) reviews of financial management issues were performed by CMS national teams at Medicare contractors. As CMS progresses toward its long-term goal of

developing an integrated general ledger system, we continue to provide training to the contractors to promote a uniform method of reporting and accounting for accounts receivable and related financial data.

## Material Weakness 2: Medicare Electronic Data Processing (EDP) Controls

CMS relies on extensive EDP operations at both our central office and the Medicare contractors to administer the Medicare program and to process and account for Medicare expenditures. Internal controls over these operations are essential to ensure the integrity, confidentiality, and reliability of critical data while reducing the risk of errors, fraud, and other illegal acts. In FY 2000, weaknesses at the Medicare contractors, as well as certain application control weaknesses at the contractors' shared systems, were prevalent. Such weaknesses do not effectively prevent 1) unauthorized access to and disclosure of sensitive information, 2) malicious changes that could interrupt data processing or destroy files, 3) improper Medicare payments, or 4) disruption of critical operations. In FY 2000, the OIG aggregated the findings at the Medicare contractors and CMS central office into one material weakness. No findings at a single location were considered material.

CMS recognizes the significance of controls and security issues regarding Medicare EDP issues as they relate to the integrity, confidentiality and availability of sensitive Medicare data. CMS has established an enterprise-wide systems security program. That portion applying to internal systems has been phasing in since late FY 1998. The first major accomplishment was the development of CMS's Systems Security Plan (SSP) Methodology, which established procedures for developing a 3-tiered hierarchical SSP structure. The first tier is the enterprise-wide systems security master plan. Tiers 2 & 3 apply to the development of general support system (GSS) and SSPs, which are applicable enterprise-wide. The Master SSP and a number of GSS SSPs are currently under development.

CMS has revised its information systems security requirements for Medicare contractors. The revision includes CMS Core Information Security Requirements. The core requirements are based on a synthesis of OMB Circular A-130, PDD 63, General Accounting Office Federal Information System Controls Audit Manual, Internal Revenue Service Publication 1075, Health Insurance Portability and Accounting Act, and new CMS requirements for systems architecture and security handbook.

### *Noncompliance*

CMS's financial management systems—because they are not integrated—do not conform to government-wide requirements. We are following a comprehensive plan to bring our systems into compliance with the requirements. We have procured a systems integrator to implement the Healthcare Integrated General Ledger Accounting System (HIGLAS). Two Medicare contractors were selected to pilot the system. Meanwhile, CMS will continue to work closely with the OIG to identify and address additional improvements.

# CONGRESSIONAL REPORTS

## Medicare's Validation Program for Hospitals Accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) Federal FY 2000 Report

### *Introduction*

Section 1865 of the Social Security Act (the Act) provides that JCAHO-accredited hospitals are deemed to meet the Medicare conditions of participation (CoPs). These hospitals are not subject to routine State surveys to assess compliance with the Medicare CoPs. Subsection 1864(c) of the Act, however, authorizes the Secretary to enter into an agreement with any State to survey hospitals accredited by the JCAHO on a selective sample basis or in response to allegations of significant deficiencies that affect the health and safety of patients. The Act further requires, at Section 1875, that the Secretary include an evaluation of the JCAHO accreditation process for hospitals in an annual report to Congress. This evaluation is referred to as the validation program.

The purpose of the validation program is to determine whether the JCAHO's accreditation process provides reasonable assurance that accredited hospitals comply with the statutory requirements at section 1861(e) of the Act for participation in the Medicare program as hospitals. Each year, the Centers for Medicare & Medicaid Services (CMS) randomly select approximately 5 percent of all JCAHO-accredited hospitals for validation surveys. Sample validation surveys may fall into three categories. They are:

1. Random sample (hospitals randomly selected for survey within 60 days after the JCAHO survey);
2. 18-month sample (hospitals randomly selected for survey at the midpoint of their 3-year JCAHO accreditation cycle); and
3. Conditional sample (hospitals randomly selected that had a JCAHO accreditation decision of conditional).

In fiscal year 2000, the JCAHO discontinued conducting the 18-month mid-cycle survey and went to a 9-30 month unannounced survey. Therefore, the random sample selected for validation survey did not include 18-month mid-cycle surveys. No JCAHO accreditation surveys that resulted in an accreditation decision of conditional were selected in the random sample of validation surveys for this reporting period.

The JCAHO accreditation survey assesses a hospital's compliance with the JCAHO's standards. After completion of the on-site survey, the JCAHO makes an accreditation decision. The accreditation decisions include: accreditation, accreditation with Type I recommendations, conditional accreditation, and no accreditation. In January 2000, the JCAHO discontinued the accreditation decision called accreditation with commendation.

Accreditation means that the hospital meets all JCAHO standards and requirements. Accreditation with Type I recommendations means that the hospital is granted accreditation with the assurance that the identified recommendations for improvement are corrected. The JCAHO requires hospitals with Type I recommendations to submit a written progress report or undergo a follow up survey. Conditional accreditation results when a hospital is not in substantial compliance with JCAHO standards but is believed to be capable of achieving acceptable standards compliance within a stipulated time period. Findings of correction, which serve as the basis for further consideration of awarding full accreditation, must be demonstrated through a short-term follow up survey. Table 1 summarizes the JCAHO's accreditation decisions for Medicare-approved hospitals receiving a triennial survey in calendar years 1999 and 2000.

**Table 1**
**JCAHO Accreditation Decisions,**
**Medicare-Approved Hospitals Surveyed in 1999 and 2000**

| Accreditation Decisions | No. Hospitals in 1999 (Percent) | No. Hospitals in 2000 (Percent) |
|---|---|---|
| Accreditation | 187 (10.9) | 146 (9.5) |
| Accreditation With Type I Recommendations | 1506 (87.5) | 1355 (87.8) |
| Conditional | 26 (1.5) | 41 (2.7) |
| Total Surveyed[2] | 1721 (100) | 1543 (100) |

## *Validation Survey Findings*

Table 2 presents the number of random validation surveys CMS performed, along with the compliance determinations (i.e., if the results of a validation survey showed noncompliance with one or more CoPs, the hospital was 'out of compliance'). A hospital may have had deficiencies of a lesser severity (e.g., standard level) and still be considered in compliance. This table also includes a comparison of the compliance pattern between validation surveys of accredited hospitals and routine surveys of nonaccredited hospitals.

[1] JCAHO accreditation decisions also include preliminary non-accreditation and provisional accreditation. [CMS does not recognize provisional accreditation for deeming.] The JCAHO considers all hospitals to be 'accredited' except those that are not accredited. CMS currently accepts the JCAHO definition of 'accredited' for deeming purposes.

[2] Categories do not sum to total because table does not include all accreditation categories.

**Table 2**
**Compliance Determinations of Validation and Non-accredited Hospital Surveys, 2000**

| Validation Type | No. Hospitals Out of Compliance | No. Hospitals In Compliance | Total |
|---|---|---|---|
| Sample Validations | 61 | 123 | 184 |
| Routine Non-accredited | 12 | 376 | 388 |

Table 3 presents the percentage of JCAHO-accredited hospitals found out of compliance by category of validation survey for the years, 1998 through 2000.

**Table 3**
**Percent of JCAHO Accredited Hospitals Out of Compliance by Category for Validation Survey Periods 1998 -1999**

| Survey Type | 1998 | 1999 | 2000 |
|---|---|---|---|
| Random | 23 | 31 | 33 |
| 18-Month | NA [3] | NA [3] | NA [3] |
| Conditional | NA [3] | NA [3] | NA [3] |

Deficiency data were analyzed for 22 Medicare hospital CoPs:

| | | |
|---|---|---|
| Federal, State, and Local Laws | Emergency Services | Anesthesia Services |
| Governing Body | Respiratory Care Services | Rehabilitation Services |
| Medical Staff | Nursing Services | Food & Dietetic Services |
| Infection Control | Pharmaceutical Services | Outpatient Services |
| Quality Assurance | Laboratory Services | Medical Records Services |
| Discharge Planning | Surgical Services | Nuclear Medicine Services |
| Patient Rights | Physical Environment | Radiologic Services |
| | Organ Procurement | |

The three health and safety CoPs found out of compliance most frequently for the 184 validation surveys performed in 2000 are shown in Table 4. The three CoPs found out of compliance most frequently for the 388 non-accredited hospitals surveyed in 2000 are shown for comparison.

[3] Small or non-existent sample. Three JCAHO conditionally accredited hospitals were selected for validation surveys in 1998 and they were in compliance with the CoPs.

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**Table 4**
**Most Frequently Cited Conditions of Participation During Surveys, 2000**

| Accredited Hospitals | Frequency | Non-accredited Hospitals | Frequency |
|---|---|---|---|
| 1 Physical Environment (includes Life Safety Code) | 43 | Quality Assurance | 20 |
| 2 Quality Assurance | 6 | Physical Environment (includes Life Safety Code) | 16 |
| 3 Nursing Services | 5 | Infection Control | 10 |
| | | Governing Body | 10 |

## Allegation Surveys

In addition to the random validation surveys, CMS conducts substantial allegation (complaint) surveys of JCAHO-accredited hospitals in response to complaints involving potential threats to the health and safety of patients. CMS evaluates each complaint. If CMS believes that the hospital would have a CoP out of compliance, the Agency authorizes the State to conduct a substantial allegation survey.

In fiscal year 2000, 2,127 allegation surveys of JCAHO-accredited hospitals were conducted with 122 found out of compliance with one or more CoPs. This means 6 percent of the allegation surveys were substantiated by findings of non-compliance. Also, 330 allegation surveys of non-accredited hospitals were conducted with 43 found out of compliance with one or more CoPs. Table 5 summarizes the most frequently cited CoPs found during allegation surveys of accredited and non-accredited hospitals.

**Table 5**
**Most Frequently Cited Conditions of Participation, During Allegation Surveys, 2000**

| Accredited Hospitals | | Nonaccredited Hospitals | |
|---|---|---|---|
| **Condition Not Met** | **Frequency** | **Condition Not Met** | **Frequency** |
| Nursing Services | 29 | Quality Assurance | 8 |
| | | Nursing Services | 8 |
| Quality Assurance | 24 | Governing Body | 6 |
| Governing Body | 19 | Medical Staff | 4 |

## Rate of Disparity

The rate of disparity is the percentage of all sample validation surveys for which a State survey agency finds non-compliance with one or more Medicare conditions and no comparable condition level deficiency was cited by the accreditation organization. As set forth in regulation at 42 CFR 488.8(d), accreditation programs with a disparity rate of 20 percent or more are subject to a review to determine if that organization has adopted and maintains requirements comparable to CMS's. Of the 184 validation surveys performed in JCAHO accredited hospitals in FY 2000, the State survey agencies found non-compliance with one or more conditions of participation in 61 hospitals. Comparing the validation survey reports of these hospitals with the JCAHO accreditation survey reports, 12 of the 61 accreditation reports had comparable condition-level findings. This equals an overall disparity rate of 27 percent. Life safety code deficiencies account for 70 percent of the overall disparity rate. In accordance with regulations at 488.8(d), CMS will review the JCAHO requirements for life safety code (including standards, environment of care, and survey process) as they compare to CMS requirements.

CMS has initiated the review process by meeting with the JCAHO regarding the increasing disparity between their physical environment/life safety code surveys as compared to the State Agency findings. Specifically, CMS is examining how JCAHO evaluates hospital compliance with LSC through facility self-assessment and the JCAHO Plans for Improvement (PFI) documents. If a JCAHO surveyor identifies a LSC deficiency that has not been self-reported on the PFI by the hospital, it is "scored" (i.e., it becomes a recommendation on the accreditation report). A self-assessed deficiency is not scored and reported on the Accreditation Report unless the surveyor determines that the hospital is making little or no progress in correcting that deficiency. CMS surveys do not include a self-assessment by the hospital. Any deficiencies noted by State surveyors are included on the Federal Form CMS-2567, Statement of Deficiencies and Plan of Correction.

Another area that will be examined under our review with the JCAHO are the differences in the two editions of the LSC used by CMS (1985 edition) and the JCAHO (1997 edition) and the reporting forms used by each. These differences do not allow for the development of an easily used crosswalk between the two survey processes. As a result, comparison of specific LSC deficiencies found using the JCAHO self-assessment methodology and the CMS survey process is difficult. CMS and JCAHO are both planning to adopt the 2000 LSC. On October 26, 2001 CMS published a Notice of Proposed Rule Making to update the CMS survey process to use the 2000 edition of the LSC procedures. Adopting the same LSC edition will allow the creation of a crosswalk between the CMS and JCAHO survey processes. However, as the State agencies and JCAHO move forward with the implementation of the 2000 edition of LSC, CMS will work together with the JCAHO to revisit the practice of allowing a facility to self-assess their compliance with LSC standards.

CMS has notified the JCAHO of the above mentioned findings and advised them that a review of their life safety code program is indicated. CMS is taking a prospective approach to improving JCAHO performance in this area beginning with the

implementation of the 2000 edition of LSC. CMS and JCAHO have both committed to working together to ensure that JCAHO's life safety code standards and survey requirements are at least as strong as Medicare's.

## Changing the Evaluation Methodology and Future Plans for Validation

There are approximately 6,032 hospitals participating in Medicare and 4,540 are accredited by the JCAHO. The 1999 OIG Reports prompted CMS to redesign the hospital validation program in order to improve JCAHO accountability for its performance when reviewing these hospitals. In response to the OIG recommendations CMS reviewed the weaknesses of the current hospital validation program and developed two new validation survey types designed to improve CMS's oversight of hospital accreditation organizations. The two new survey types identified were 1) Concurrent/Observational Validation Survey, and 2) Focused Survey. CMS will also continue to conduct some validation surveys using the traditional 60-day look behind methodology.

The Concurrent/Observational Survey is an announced survey with a Regional Office surveyor(s) observing the JCAHO triennial accreditation survey while the State survey agency concurrently conducts a full comparative survey. Regional Office observers record their observations of JCAHO standard implementation, survey process and surveyor performance. The Focused Survey is designed to be an unannounced survey to determine a hospital's ability to maintain compliance with Medicare CoPs between JCAHO accreditation surveys. The Focused Survey examines specific standards of national or regional interest to CMS.

CMS initiated the pilot Concurrent/Observational survey in January 2001. The first phase of the pilot has been completed. CMS and JCAHO worked in close collaboration to orchestrate and complete the pilot concurrent/observational surveys. The FY 2001 Focused surveys have also been conducted based on select conditions of participation. The selected CoPs, based on areas of national interest, are Nursing Services, Pharmaceutical Services, Quality Assurance as it pertains to Pharmaceutical Services and Medication Administration, and Patient Rights. CMS has collected data on these surveys as well as feedback from the accrediting organization, Regional Office and State surveyors and the hospitals that were surveyed. CMS is in the process of analyzing the data and the survey findings. In addition, an independent contractor has been obtained to evaluate the effectiveness of the revised hospital validation program and the outcomes of the survey pilots.

We look forward to sharing the outcomes of the survey pilots, data analysis and findings of the independent contractor in next year's report.

# VALIDATION SURVEYS OF ACCREDITED LABORATORIES UNDER THE CLINICAL LABORATORY IMPROVEMENT AMENDMENTS OF 1988 (CLIA) – 2000 REPORT

## Introduction

This report covers the evaluations of fiscal year 2000 performance by the six accreditation organizations approved under CLIA. The six organizations are:

- American Association of Blood Banks (AABB)
- American Osteopathic Association (AOA)
- American Society of Histocompatibility and Immunogenetics (ASHI)
- College of American Pathologists (the College)
- Commission on Office Laboratory Accreditation (COLA)
- Joint Commission on Accreditation of Healthcare Organizations (Joint Commission)

We appreciate the cooperation of all of the organizations in providing their inspection schedules and results. While an annual performance evaluation of each approved accreditation organization is required by law, we see this as an opportunity to present information about, and dialogue with, each organization in our mutual interest in improving the quality of testing performed by clinical laboratories across the nation.

### *Legislative Authority and Mandate*

Section 353 of the Public Health Service Act, as amended by the Clinical Laboratory Improvement Amendments of 1988 (CLIA), requires any laboratory that performs testing on human specimens to meet the requirements established by the Department of Health and Human Services (HHS) and have in effect an applicable certificate. Section 353 further provides that a laboratory meeting the standards of an approved accreditation organization may obtain a CLIA Certificate of Accreditation. Under the CLIA Certificate of Accreditation, the laboratory is not routinely subject to direct Federal oversight by CMS. Instead, the laboratory receives an inspection by the accreditation organization in the course of maintaining its accreditation, and by virtue of this accreditation, is “deemed” to meet the CLIA requirements. The CLIA requirements pertain to quality assurance and quality control programs, records, equipment, personnel, proficiency testing and others to assure accurate and reliable laboratory examinations and procedures.

In Section 353(e)(2)(D), the Secretary is required to evaluate each approved accreditation organization by inspecting a sample of the laboratories they accredit and "such other means as the Secretary determines appropriate." In addition, Section 353(e)(3) requires the Secretary to submit to Congress an annual report on the results of the evaluation. This report is submitted to satisfy that requirement.

Regulations implementing Section 353 are contained in 42CFR Part 493 Laboratory Requirements. Subpart E of Part 493 contains the requirements for validation inspections, which are conducted by CMS or its agent to ascertain whether the laboratory is in compliance with the applicable CLIA requirements. Validation inspections are conducted no more than 90 days after the accreditation organization's inspection, on a representative sample basis or in response to a complaint. The results of these validation inspections or surveys provide:

- on a laboratory-specific basis, insight into the effectiveness of the accreditation organization's standards and accreditation process; and
- in the aggregate, an indication of the organization's capability to assure laboratory performance equal to or more stringent than that required by CLIA.

The CLIA regulations, in Section 493.575 of Subpart E, provide that if the validation inspection results over a one-year period indicate a rate of disparity of 20 percent or more between the findings in the accreditation organization's results and the findings of the CLIA validation surveys, CMS can re-evaluate whether the accreditation organization continues to meet the criteria for an approved accreditation organization (also called "deeming authority"). Section 493.575 further provides that CMS has the discretion to conduct a review of an accreditation organization program if validation review findings, irrespective of the rate of disparity, indicate such widespread or systematic problems in the organization's accreditation process that the requirements are no longer equivalent to CLIA requirements.

## *Validation Reviews*

The validation review methodology focuses on the actual implementation of an organization's accreditation program described in its request for approval. The accreditation organization's standards, as a whole, were approved by CMS as being equivalent to, or more stringent than, the CLIA condition-level requirements,* as a whole. This equivalency is the basis for granting deeming authority.

In evaluating the organization's performance, it is important to examine whether the organization's inspection findings are similar to the CLIA validation survey findings. It is also important to examine whether the organization's inspection process sufficiently identifies, brings about correction, and monitors for sustained correction, laboratory practices and outcomes that do not meet their accreditation standards, so that equivalency of the accreditation program is maintained.

* A condition-level requirement pertains to the significant, comprehensive requirements of CLIA, as opposed to a standard-level requirement, which is more detailed, more specific. A condition-level deficiency is an inadequacy in the laboratory's quality of services that adversely affects, or has the potential to adversely affect, the accuracy and reliability of patient test results.

For each laboratory in the sample, any findings from the CLIA validation survey that result in deficiencies at the condition-level are compared to the accreditation organization's inspection results to determine comparability. If it is reasonable to conclude that one or more of those deficiencies were present in the laboratory's operations at the time of the organization's inspection, yet the inspection results did not note them, the case is a disparity. When all the cases in each sample have been reviewed, the rate of disparity for each organization is calculated by dividing the number of disparate cases by the total number of validation surveys, in the manner prescribed by Section 493.2 of the CLIA regulations.

## Number of Validation Surveys Performed

As directed by the CLIA statute, the number of validation surveys should be sufficient to allow a reasonable estimate of the performance of each accreditation organization. A representative sample of the more than 14,000 accredited laboratories received a validation survey in 2000. Laboratories seek and relinquish accreditation on an ongoing basis, so the number of laboratories accredited by an organization during any given year fluctuates. Moreover, many laboratories are accredited by more than one organization. Each laboratory holding a Certificate of Accreditation, however, is subject to only one validation survey for the organization it selected to maintain its CLIA certification irrespective of the number of accreditations it maintains.

Nationwide, fewer than 500 of the accredited laboratories used AABB, AOA, or ASHI accreditation for CLIA purposes. Given these proportions, very few validation surveys were performed in laboratories accredited by those organizations. The overwhelming majority of accredited laboratories in the CLIA program used their accreditation by COLA, the College or the Joint Commission, thus the sample sizes for these organizations were larger. The sample sizes are usually proportionate to each organization's representation in the universe of accredited laboratories, however true proportionality is not always possible due to scheduling difficulties.

The number of validation surveys performed for each organization is specified in the summary findings for the organization.

## Results of the Validation Reviews of Each Accreditation Organization

### American Association of Blood Banks

Rate of disparity: No disparity

Approximately 250 laboratories used their AABB accreditation for CLIA purposes. Seven validation surveys were conducted. No condition-level deficiencies were cited on any of the surveys, thus disparity was precluded.

### American Osteopathic Association

Rate of disparity: No disparity

For CLIA purposes, approximately 50 laboratories used their AOA accreditation. Five validation surveys were conducted. This year, as in the previous years of CLIA validation review, disparity was precluded because no condition-level deficiencies were cited on any of the surveys.

**American Society of Histocompatibility and Immunogenetics**

Rate of disparity: No disparity

Approximately 130 laboratories used their ASHI accreditation for CLIA purposes. Two validation surveys were considered reasonable to evaluate this organization's performance. Condition-level compliance was found in both validation surveys, thus disparity was precluded this year, as in the previous years of CLIA validation review.

**COLA**

Rate of disparity: 7 percent

Validation surveys were conducted at 106 COLA-accredited laboratories. Fifteen laboratories were cited with condition-level deficiencies. Comparable deficiencies were not noted by COLA in seven of those laboratories.

Following is a listing of the laboratory identification number, location and condition-level deficiencies of the laboratories where COLA findings were disparate.

| CLIA number | Location | CLIA Conditions |
|---|---|---|
| 04D0465432 | Arkansas | Proficiency Testing—Chemistry, failure to participate |
| 15D0678428 | Indiana | Proficiency Testing—Successful Participation |
| 17D0452948 | Kansas | Proficiency Testing—Successful Participation |
| 26D0442331 | Missouri | Proficiency Testing—Successful Participation |
| 36D0343708 | Ohio | Proficiency Testing—Successful Participation |
| 52D0393128 | Wisconsin | Quality Assurance |
| 45D0677554 | Texas | Quality Control—Bacteriology |

**College of American Pathologists**

Rate of disparity: 7 percent

A total of 75 validation surveys were actually conducted at laboratories accredited by the College, however, one was removed from the pool for administrative reasons. Six of the laboratories were cited with condition-level deficiencies. Comparable deficiencies were cited by the College in only one of those cases.

Following is a listing of the CLIA identification number, location and condition-level deficiencies where the College's findings were disparate.

| CLIA number | Location | CLIA Conditions |
|---|---|---|
| 04D0467545 | Arkansas | Quality Assurance |
| 07D0099891 | Connecticut | Technical Supervisor |
| 21D0209880 | Maryland | Patient Test Management, Quality Assurance |
| 21D0215764 | Maryland | Quality Control—Cytology, Laboratory Director |
| 32D0668699 | New Mexico | Quality Control—Routine Chemistry<br>Quality Assurance, Laboratory Director,<br>Technical Consultant |

**Joint Commission on Accreditation of Healthcare Organizations**

Rate of disparity: 7 percent

During this validation period, 71 validation surveys were conducted at laboratories accredited by the Joint Commission. Six of the laboratories were cited with condition-level deficiencies, however, comparable deficiencies were noted by the Joint Commission in only one of those cases.

Following is a listing of the CLIA identification number, location and condition-level deficiencies of the laboratories where the Joint Commission's findings were disparate.

| CLIA number | Location | CLIA Conditions |
|---|---|---|
| 14D0436319 | Illinois | Quality Assurance, Quality Control |
| 18D0323681 | Kentucky | Quality Assurance |
| 36D0343065 | Ohio | Quality Assurance |
| 45D0495463 | Texas | Quality Assurance |
| 45D0880844 | Texas | Quality Assurance |

## *Conclusion*

CMS has performed this validation review in order to evaluate and report to Congress on the performance of the six laboratory accreditation organizations approved under CLIA. The findings of the validation review for fiscal year 2000 indicate that all of the accreditation organizations performed at a level well below the 20 percent threshold that would trigger a deeming authority review. Moreover, the validation review did not reveal widespread or systematic problems in accreditation processes that cause the equivalency of any organization's accreditation program to be questioned.

In addition to assessing each organization's program equivalency through validation surveys, CMS has been active in promoting opportunities for partnering with the organizations in furthering our mutual interest in improving laboratory practices and outcomes across the nation. The 1999 Report noted the development of a protocol for a "simultaneous validation survey", which is conducted at the same time as the accreditation inspection. Designed as an alternative to the "look-behind" timing traditionally used for validation surveys, it was instituted nationwide on a trial basis in 1999 as a supplemental approach. While there were challenges in the logistics of scheduling and coordinating surveys as well as accompanying the larger teams used by

one accreditation organization, the feedback was positive overall. Some feedback related the mutual realization by CLIA surveyor and accreditation inspector that each can learn from the other's perspective for ensuring quality in laboratory testing. Many laboratories indicated a preference for a simultaneous visit by both agencies rather than separate visits. As a result, the protocol for simultaneous surveys was modified to better address the challenges, and was instituted on a permanent basis as a supplement to the look-behind protocol.

# REPORT ON PEER REVIEW ORGANIZATIONS (PRO)

Over the last several years, CMS has re-engineered the PRO program to better meet the Agency's strategic goal of improving the health status of Medicare beneficiaries. PROs still perform quality assurance activities in accordance with their original mandate. However, the principal focus of the PRO program has evolved from a mix of utilization review, diagnosis related group (DRG) validation and quality of care review to an expanded approach that features emphasis on quality improvement projects through the Health Care Quality Improvement Program (HCQIP). For the sixth round of PRO contracts, now entering the final year of a 3-year cycle, a substantial level of effort is also being directed at Medicare program integrity via the Payment Error Prevention Program (PEPP) in compliance with the Balanced Budget Act.

The HCQIP relies on provider-based quality improvement, a data driven external monitoring system based on quality indicators, and sharing of comparative data and best practices with providers to stimulate improvement. PROs conduct a wide variety of improvement projects on important clinical and non-clinical topics that have the potential to improve care provided to many Medicare beneficiaries. Such projects vary in size depending on the study purpose and design. For example, there are national projects featuring six clinical topic areas (acute myocardial infarction, heart failure, diabetes, breast cancer, pneumonia, and stroke) that CMS has determined to have a high impact on Medicare beneficiaries; where the process measures are linked to outcomes; where room for improvement exists; and where PROs have experience with the topic. Similarly, individual PROs also design and structure local projects whereby they work collaboratively with specific providers and managed care plans in their areas, particularly with respect to disadvantaged and/or under-served beneficiary groups. PROs also conduct pilot projects in alternative provider settings.

Consistent with the Agency's strategic goal to promote the fiscal integrity of CMS programs, the PEPP activities are part of the Comprehensive Plan for Program Integrity to ensure Medicare hospital inpatient claims are billed and paid appropriately. Using CMS-developed baseline data, each PRO is now required to identify the extent of payment errors occurring in its area; implement appropriate educational interventions aimed at changing provider behavior; and decrease the observed payment error rate. The overall

target for the 3-year contract period is a 50 percent reduction nationally in payment errors for claims by acute care hospitals under Medicare's Prospective Payment System.

Under Federal budget rules, the PRO program is defined as mandatory rather than discretionary because PRO costs are financed directly from the Medicare Trust Funds and are not subject to the annual appropriations process. PRO outlays in FY 2001 totaled $329.2 million, which compares with $278.7 million spent in FY 2000.

In FY 2001, CMS administered 53 PRO performance-based contracts, one per State, the District of Columbia, the Virgin Islands, and Puerto Rico. Program compliance is ensured via performance-based evaluation measures for both project results and program integrity efforts, as well as use of inter-rater reliability measures and International Organization for Standardization (ISO) 9000-type documentation of PRO processes.

U.S. Department of Health and Human Services
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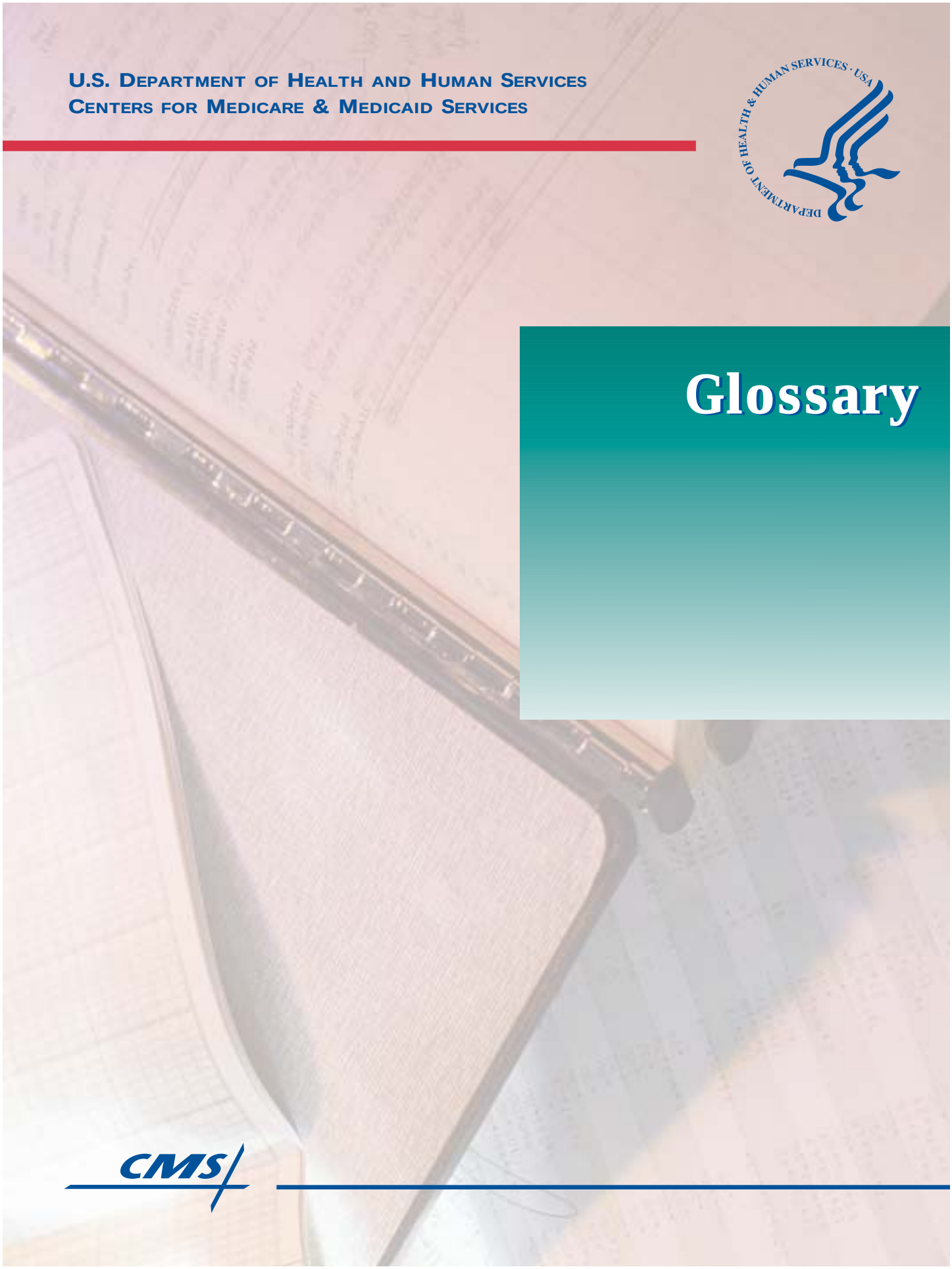

# Glossary

CMS

# GLOSSARY

**Accrual Accounting:** An accounting technique that recognizes costs when incurred and revenues when earned and includes the effect of accounts receivable and accounts payable when determining annual income.

**Actuarial Soundness:** A measure of the adequacy of Hospital Insurance and Supplementary Medical Insurance financing as determined by the difference between trust fund assets and liabilities for specified periods.

**Administrative Costs:** General term that refers to Medicare and Medicaid administrative costs, as well as CMS administrative costs. Medicare administrative costs are comprised of the Medicare related outlays and non-CMS administrative outlays. Medicaid administrative costs refer to the Federal share of the States' expenditures for administration of the Medicaid program. CMS administrative costs are the costs of operating CMS (e.g. salaries and expenses, facilities, equipment, rent and utilities, etc). These costs are reflected in the Program Management account.

**Balanced Budget Act of 1997 (BBA):** Major provisions include the State Children's Health Insurance Program, Medicare+Choice, and expansion of preventive benefits.

**Beneficiary:** A person entitled under the law to receive Medicare or Medicaid benefits (also referred to as an "enrollee").

**Benefit Payments:** Funds outlayed or expenses accrued for services delivered to beneficiaries.

**Carrier:** A private business, typically an insurance company, which contracts with CMS to receive, review, and pay physician and supplier claims.

**Cash Accounting:** An accounting technique that tracks outlays or expenditures during the current period regardless of the fiscal year the service was provided or the expenditure was incurred.

**Cost-Based Health Maintenance Organization (HMO/Competitive Medical Plan, CMP):** A type of managed care organization that will pay for all of the enrollees/members' medical care costs in return for a monthly premium, plus any applicable deductible or co-payment. The HMO will pay for all hospital costs (generally referred to as Part A) and physician costs (generally referred to as Part B) that it has arranged for and ordered. Like a health care prepayment plan (HCPP), except for out-of-area emergency services, if a Medicare member/enrollee chooses to obtain services that have not been arranged for by the HMO, he/she is liable for any applicable deductible and co-insurance amounts, with the balance to be paid by the regional Medicare intermediary and/or carrier.

**Demonstrations:** Projects and contracts that CMS has signed with various health care organizations. These contracts allow CMS to test various or specific attributes such as payment methodologies, preventive care, social care, etc., and to determine if such

projects/pilots should be continued or expanded to meet the health care needs of the Nation. Demonstrations are used to evaluate the effects and impact of various health care initiatives and the cost implications to the public.

**Discretionary Spending:** Outlays of funds subject to the Federal appropriations process.

**Disproportionate Share Hospital (DSH):** A hospital with a disproportionately large share of low-income patients. Under Medicaid, States augment payment to these hospitals. Medicare inpatient hospital payments are also adjusted for this added burden.

**Durable Medical Equipment (DME):** Purchased or rented items such as hospital beds, wheelchairs, or oxygen equipment used in a patient's home.

**Durable Medical Equipment Regional Carrier (DMERC):** A company that contracts to pay Medicare claims for purchased or rented items such as hospital beds, wheelchairs, or oxygen equipment used in a patient's home.

**Expenditure:** Expenditure refers to budgeted funds actually spent. When used in the discussion of the Medicaid program, expenditures refer to funds actually spent as reported by the States. This term is used interchangeably with Outlays.

**Expense:** An outlay or an accrued liability for services incurred in the current period. This term is used to show accrual accounting.

**Federal General Revenues:** Federal tax revenues (principally individual and business income taxes) not earmarked for a particular use.

**Federal Insurance Contribution Act (FICA) Payroll Tax:** Medicare's share of FICA is used to fund the HI Trust Fund. In FY 1999, employers and employees each contributed 1.45 percent of taxable wages, with no limitations, to the HI Trust Fund.

**Federal Medical Assistance Percentage (FMAP):** The portion of the Medicaid program which is paid by the Federal government.

**Federal Managers' Financial Integrity Act (FMFIA):** A program to identify management inefficiencies and areas vulnerable to fraud and abuse and to correct such weaknesses with improved internal controls.

**Health Care Prepayment Plan (HCPP):** A type of managed care organization. In return for a monthly premium, plus any applicable deductible or co-payment, all or most of an individual's physician services will be provided by the HCPP. The HCPP will pay for all services it has arranged for (and any emergency services) whether provided by its own physicians or its contracted network of physicians. If a member enrolled in an HCPP chooses to receive services that have not been arranged for by the HCPP, he/she is liable for any applicable Medicare deductible and/or coinsurance amounts, and any balance would be paid by the regional Medicare carrier.

# GLOSSARY

**Health Insurance Portability and Accountability Act of 1996 (HIPAA):** Major provisions include portability provisions for group and individual health insurance, establishes the Medicare Integrity Program, and provides for standardization of health data and privacy of health records.

**Hospital Insurance (HI):** The part of Medicare that pays hospital and other institutional provider benefit claims. See "Part A."

**Information Technology (IT):** The term commonly applied to maintenance of data through computer systems.

**Intermediary:** A private business, typically an insurance company, which contracts with CMS to receive, review, and pay hospital and other institutional provider benefit claims.

**Internal Controls:** Management systems and policies for reasonably documenting, monitoring, and correcting operational processes to prevent and detect waste and to ensure proper payment. Also known as Management controls.

**Mandatory Spending:** Outlays for entitlement programs (Medicare and Medicaid) that are not subject to the Federal appropriations process.

**Material Weakness:** A serious flaw in management or internal controls requiring high priority corrective action.

**Medicare Current Beneficiary Survey (MCBS):** A comprehensive source of information on the health, health care, and socioeconomic and demographic characteristics of aged, disabled, and institutional Medicare beneficiaries.

**Medicare Contractor:** A collective term for carriers and intermediaries.

**Medicare+Choice:** A provision in the BBA that restructures CMS's authority to contract with a variety of managed care entities, including health maintenance organizations (HMO) and Competitive Medical Plans (CMP), both of which were previously allowed to participate in Medicare, as well as preferred provider organizations (PPO) and preferred supplier organizations (PSO), religious fraternal benefit society plans, private fee-for-service-plans, and medical saving accounts (MSAs), for which the BBA authorizes a special demonstration for up to 390,000 beneficiaries.

**Medicare Integrity Program (MIP):** A provision in HIPAA that sets up a revolving fund to support CMS's program integrity program.

**Medicare Trust Funds:** Treasury accounts established by the Social Security Act for the receipt of revenues, maintenance of reserves, and disbursement of payments for the HI and SMI programs.

# GLOSSARY

**Medical Review/Utilization Review (MR/UR):** Contractor reviews of Medicare claims to ensure that the service was necessary and appropriate.

**Medicare Secondary Payer (MSP):** A statutory requirement that private insurers providing general health insurance coverage to Medicare beneficiaries pay beneficiary claims as primary payers.

**Obligation:** Budgeted funds committed to be spent.

**Outlay:** Budgeted funds actually spent. When used in the discussion of the Medicaid program, outlays refer to amounts advanced to the States for Medicaid benefits. Used for cash accounting.

**Part A:** The part of Medicare that pays hospital and other institutional provider benefit claims, also referred to as Medicare Hospital Insurance or "HI."

**Part B:** The part of Medicare that pays physician and supplier claims, also referred to as Medicare Supplementary Medical Insurance or "SMI."

**Payment Safeguards:** Activities to prevent and recover inappropriate Medicare benefit payments, including MSP, MR/UR, provider audits, and fraud and abuse detection.

**Peer Review Organization (PRO):** PROs monitor the quality of care provided to Medicare beneficiaries to ensure that health care services are medically necessary, appropriate, provided in a proper setting, and are of acceptable quality.

**Program Management:** CMS's operational account. Program Management supplies the agency with the resources to administer Medicare, the Federal portion of Medicaid, and other Agency responsibilities. The components of Program Management are: Medicare contractors, survey and certification, research, and administrative costs.

**Provider:** A health care professional or organization providing medical services.

**Recipient:** An individual covered by the Medicaid program, however, now referred to as a beneficiary.

**Risk-Based Health Maintenance Organization (HMO)/Competitive Medical Plan (CMP):** A type of managed care organization. After any applicable deductible or co-payment, all of an enrollee/member's medical care costs are paid for in return for a monthly premium. However, due to the "lock-in" provision, all of the enrollee/member's services (except for out-of-area emergency services) must be arranged for by the risk HMO. Should the Medicare enrollee/member choose to obtain service not arranged for by the plan, he/she will be liable for the costs. Neither the HMO nor the Medicare program will pay for services from providers that are not part of the HMO's health care system/network.

# GLOSSARY

**Revenue:** The recognition of income earned and the use of appropriated capital from the rendering of services in the current period.

**Self Employment Contribution Act (SECA) Payroll Tax:** Medicare's share of SECA is used to fund the HI Trust Fund. In FY 1999, self-employed individuals contributed 2.9 percent of taxable annual income, with no limitation.

**State Certification:** Inspections of Medicare provider facilities to ensure compliance with Federal health, safety, and program standards.

**State Children's Health Insurance Program (SCHIP) (also known as Title XXI):** This is a provision of the BBA that provides federal funding through CMS to States so that they can expand child health assistance to uninsured, low-income children.

**Supplementary Medical Insurance (SMI):** The part of Medicare that pays physician and supplier claims. See "Part B."

**Tax and Donations**: State programs under which funds collected by the State through certain health care related taxes and provider-related donations were used to effectively increase the amount of Federal Medicaid reimbursement without a comparable increase in State Medicaid funding or provider reimbursement levels.

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## U.S. Department of Health and Human Services

**Tommy G. Thompson**, Secretary

## Centers for Medicare & Medicaid Services

**Thomas A. Scully**, Administrator

The Chief Financial Officers (CFO) Act of 1990 (P.L. 101-576) marks a major effort to improve U.S. Government financial management and accountability. In pursuit of this goal, the Act instituted a new Federal financial management structure and process modeled on private sector practices. It also established in all major agencies the position of Chief Financial Officer with responsibilities including annual publication of financial statements and an accompanying report. The form and content of this ***Financial Report*** follows guidance provided by the Department of Health and Human Services, the Office of Management and Budget, and the General Accounting Office. It reflects the Centers for Medicare & Medicaid Services's (CMS) support of the spirit and requirements of the CFO Act and our continuing commitment to improve agency financial reporting.

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